Supreme Court, U.S.
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No. _____

In The
Supreme Court of the United States

PEABODY COAL CO.,

Petitioner,

v.

WILMA J. GROVES and DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

MARK E. SOLOMONS
Counsel of Record
LAURA METCOFF KLAUS
GREENBERG TRAURIG LLP
800 Connecticut Ave., N.W.
Washington, D.C. 20006
(202) 533-2361

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

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QUESTION PRESENTED

The decision below applies a *per se* rule requiring an administrative law judge to accord a treating doctor enhanced credibility in adjudicating claims for benefits under the Black Lung Benefits Act. 30 U.S.C. §§ 901-945 ("Act" or "BLBA"). The questions presented are:

a) Does the Sixth Circuit's treating physician rule violate sections 7(c) and 12 of the Administrative Procedure Act, 5 U.S.C. §§ 556(d), 559, section 21(b) and (c) of the Longshore Act, 33 U.S.C. § 921(b), (c), and this Court's law prohibiting *per se* rules exaggerating the weight that must be accorded certain designated evidence?

b) Is the Department of Labor's treating physician rule in 20 C.F.R. § 718.104(d) invalid as applied because it is arbitrary and capricious and not in accordance with law?

LIST OF PARTIES AND RULE 29.6 STATEMENT

The petitioner, Peabody Coal Company, is a wholly owned subsidiary of Peabody Energy Corporation. Respondent Wilma Groves is a claimant for benefits under the BLBA. The Director, Office of Workers' Compensation Programs, United States Department of Labor, is the administrator of the black lung benefits program and is a statutory party in black lung claims. 30 U.S.C. § 932(k).

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PETITION FOR WRIT OF CERTIORARI

The Peabody Coal Company respectfully petitions for a writ of certiorari to review the judgment and opinion of The United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals is reported at 277 F.3d 829. Appendix ("App.") 1. The order of the court of appeals denying petitioner's petition for rehearing and suggestion for rehearing *en banc* is unreported. App. 69.

The administrative decisions all are unreported. These include:

1) The decision of the administrative law judge ("ALJ") dated June 30, 1997, denying benefits, App. 46;

2) The decision of the Benefits Review Board, United States Department of Labor, dated July 14, 1998, vacating the ALJ's denial of benefits, App. 39;

3) The decision of the ALJ, on remand dated November 24, 1998, awarding benefits, App. 26;

4) The decision of the Benefits Review Board dated December 22, 1999, affirming the ALJ's decision, App. 19; and

5) The Order of the Benefits Review Board dated May 17, 2000, denying reconsideration, App. 17.

JURISDICTION

The judgment of the Sixth Circuit was issued on January 17, 2002. A timely petition for rehearing was

denied on April 12, 2002. App. 69. On July 8, 2002, Justice Stevens extended the time to petition for a writ of certiorari to and including August 15, 2002. (Application No. 02A14). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS

The following authorities are set forth in the Appendices:

1. Section 7(c) of the Administrative Procedure Act, 5 U.S.C. § 556(d). App. 70;

2. Section 10(e) of the Administrative Procedure Act, 5 U.S.C. § 706. App. 70;

3. Section 19(d) of the Longshore and Harborworkers' Compensation Act ("LHWCA"), 33 U.S.C. § 919(d). App. 71;

4. Section 21(c) of the Longshore and Harborworkers' Compensation Act, 33 U.S.C. § 921(c). App. 72; and

5. 20 C.F.R. § 718.104(d). App. 73.

STATEMENT OF THE CASE

A. Introduction

The treating physician rule is a thumb on the scales of justice. It has no statutory source and has been repudiated by medical authority. Its sole purpose is to support an award of benefits that is not proved by the best evidence. The rule impedes substantial evidence review and promotes unreasoned decisionmaking. It is the replacement *per se* rule for the "true doubt" rule struck down by this

Court in *Director OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994), and the treating doctor rule, like its predecessor, should be rejected.

In 1997, the U.S. Department of Labor, ("DOL") published a proposed regulation adopting a treating doctor rule that permitted "controlling weight" to be accorded to the opinion of a treating doctor in black lung claims. No science authority came forward to support the rule. DOL nevertheless promulgated the rule in January 2000. 20 C.F.R. § 718.104(d). The D.C. Circuit upheld the rule following a facial attack on the theory that DOL was not required to support the rule by either a science record or valid reasoning. *National Mining Ass'n v. Dep't of Labor*, 292 F.3d 849 (D.C. Cir. 2002) ("*NMA*"). The Court also rejected the argument that the rule operates as a de facto presumption that the relationship between a doctor and patient is a medically important factor in determining the credibility of a treating doctor.[1]

The court below created its own version of the treating doctor rule to affirm an award of benefits based upon a treating doctor's medical fairy tale that was supported neither by science nor even common sense. The Sixth

[1] No petition for a writ of certiorari will be filed in *NMA*. The case involved a challenge to many provisions of a comprehensive rulemaking. The court of appeals vacated several rules on the grounds that they are impermissibly retroactive or otherwise not authorized. The rules have been remanded to DOL for appropriate corrections. The Sixth Circuit in this case looked to the new treating doctor rule for guidance, notwithstanding its technical inapplicability. The Sixth Circuit's use of the rule here and in another case to be petitioned shortly with a motion to consolidate (*Gray v. Peabody Coal Co.*, No. 01-3083, 2002 WL 655448 (6th Cir. 2002)) makes a far better and clearer presentation of the issue in an as-applied setting.

Circuit has applied its rule repeatedly in this fashion. Its continued use will have a substantial adverse impact on mine operators and insurers in Sixth Circuit states and a devastating impact on small mine operators that must purchase commercial insurance. Experience elsewhere predicts a significant adverse impact on patients and claims procedures as well.

The rule has no redeeming virtues and it has been rejected many times in many circumstances. It violates the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 556(d), 559 and 706, the Longshore Act, 33 U.S.C. § 921, and principles of fair play in litigation. It dishonors the system of adjudication for these claims by demanding substantial weight for evidence that deserves no such enhancement on its own merit. This is a remarkably bad, unfair and inappropriate rule.

The Peabody Coal Company asks the Court to review this rule.

B. Background

The BLBA is a federal workers' compensation law that provides benefits to coal miners and their families on account of total disability or death due to pneumoconiosis or "black lung" disease. *Pauley v. BethEnergy Mines, Inc.*, 501 U.S. 680 (1991). The procedures for the adjudication of black lung claims are set forth in the LHWCA. *Greenwich Collieries*, 512 U.S. at 271; 33 U.S.C. §§ 919-922, *incorporated by reference into* 30 U.S.C. § 932(a). By virtue of this incorporation, the APA also applies in the adjudication of black lung claims. In *Greenwich Collieries*, this Court rejected the DOL's claim that the APA does not apply to black lung adjudications. *Id.*

In claims filed on or after July 1, 1973, and certain other claims subject to review by DOL under 30 U.S.C. § 945, benefits are paid by a mine operator, its insurance carrier, or if no responsible operator can be found, an entity called the Black Lung Disability Trust Fund. 30 U.S.C. §§ 932(a), 934.

Disputed claims are tried by an administrative law judge ("ALJ"). Appeals from an ALJ's decision may be taken to DOL's Benefits Review Board ("Board"). The Board conducts an appellate review only to determine whether the ALJ's decision is supported by substantial evidence and in accordance with law. 33 U.S.C. § 921(b). Appeals from the Board's decisions may be taken as of right to the U.S. court of appeals with jurisdiction over the place where the miner worked for the employer. The court of appeals also conducts substantial evidence review. *Id.* § 921(c).

The Longshore Act prescribes no rules of evidence or treating doctor factor. It provides only that "common law or statutory rules of evidence or . . . technical or formal rules of procedure" do not apply except as set forth in the Longshore Act and that the adjudicator "may make such investigation or inquiry or conduct such hearing in such a manner to best ascertain the rights of the parties." 33 U.S.C. § 923(a).

The BLBA incorporates these provisions. 30 U.S.C. § 932(a). The BLBA also requires the factfinder to consider all relevant medical evidence including a treating doctor's records as well as a list of other medical information. 30 U.S.C. § 923(b).

Rulemaking for the black lung program must be conducted in conformity with 5 U.S.C. § 553. 30 U.S.C. § 926(a). Rules adopted for the program are subject to review in accordance with the criteria set forth in 5 U.S.C. § 706.

C. The Groves Claim

Elze Groves had severe arteriosclerotic heart disease, insulin dependent diabetes, uncontrolled hypertension, high cholesterol, was obese, had a thirty year cigarette smoking history and drank alcohol to excess. He retired from mining in 1988, and filed a black lung claim at that time. The claim was denied. Groves died due to a sudden heart attack on April 30, 1995. After his death, Wilma Groves filed a survivor's claim.

During the last years of his life, Groves was treated by Dr. William Blue, a family doctor. Dr. Blue's treatment notes in the record reveal no treatment for black lung disease and no mention of an occupationally related condition. Dr. Blue was not present when Elze Groves died and previously had referred Groves to specialists for the treatment he needed. None of these specialists treated Groves for black lung disease. In support of Wilma Groves's claim, however, Dr. Blue wrote a one-page letter that essentially attributed Elze's diabetes and heart disease to pneumoconiosis. App. 32. The letter contains no citation to supporting medical literature, no reference to tests performed and no rationale.

Three pulmonary disease specialists disagreed, including the DOL examiner and two experts who reviewed the medical records for Peabody. Dr. Greg Fino, a Board-certified pulmonologist, noted research reports negating the chain of causation asserted by Dr. Blue.

On June 30, 1997, an ALJ denied benefits, finding that Dr. Blue's opinion was not reasoned or documented. The ALJ, however, found that Groves had black lung disease solely on the basis of a treating doctor preference. App. 65. The Board vacated the denial of benefits, noting inconsistencies in the ALJ's analysis. App. 43-44.

On November 24, 1998, the ALJ awarded benefits on remand. App. 26. This time, the ALJ gave most credit to Dr. Blue because he treated Groves and found that Groves died due to pneumoconiosis.[2] The Benefits Review Board affirmed, citing the Sixth Circuit's decisions in *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995), and *Tussey v. Island Creek Coal Co.*, 982 F.2d 1036 (6th Cir. 1993). In *Tussey*, the Sixth Circuit held: "It is clearly established that opinions of treating physicians are entitled to greater weight than those of non-treating physicians." *Id.* at 1042.[3] The Board affirmed the ALJ's decision to discredit the pulmonary disease specialists because they did not examine or treat Groves "and were thus not as familiar with the miner's condition as Dr. Blue." The record contains no proof that having examined or treated Groves in any way enhanced Dr. Blue's insight. It is presumed that the relationship alone enhanced Dr. Blue's credibility. See App. 23-24. A timely petition for rehearing was denied without opinion. App. 17. Peabody timely appealed to the Sixth Circuit. Before the end of the briefing cycle, DOL published final new black lung regulations, including a treating doctor rule, 20 C.F.R. § 718.104(d). App. 73.

In prosecuting the appeal, Peabody argued that the treating doctor preference applied by the ALJ violated

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[2] The ALJ does not explain how he could have credited Dr. Blue's opinion after he found it was unreasoned and unsupported by medical data.

[3] The Court offered no rationale for this rule, but cited two cases, neither of which clearly established the rule in black lung cases, *Sexton v. Director, OWCP*, 752 F.2d 213 (6th Cir. 1985) (which did not involve a treating physician) and *Collins v. Sec'y of HHS*, 734 F.2d 1177 (6th Cir. 1984) (an SSA disability claim).

5 U.S.C. § 556(d) and *Greenwich Collieries*, 512 U.S. 267, by shifting the burden of proof. The rule presumes a higher degree of credibility for the treating doctor's opinion and impedes or precludes a proper weighing of the medical evidence in light of the quality of the expert's reasoning and the support for it in the medical data. Peabody argued that this Court's decision in *Allentown Mack Sales & Serv., Inc. v. NLRB*, 522 U.S. 359 (1998), further precluded the ALJ and the Court of Appeals from applying a *per se* rule exaggerating the significance of this one type of evidence and cited DOL's rulemaking record to emphasize that over the course of a four-year long effort that involved two notice-and-comment periods and an express request by DOL for assistance in developing an appropriate treating doctor rule, *see* 64 Fed. Reg. 54976 (Oct. 8, 1999), not one science authority supported the rule and all medical and scientific commentators urged DOL not to adopt it because the rule rested on no valid premise.

On January 17, 2002, the court of appeals affirmed the ALJ's decision in all respects. The court rejected Peabody's argument that *Tussey* created an absolute preference for or presumption of superiority of treating doctors' opinions. The court held that the ALJ was required only to pay "due deference" to the treating doctor's opinion and that he had done so appropriately in this case in light of the record as a whole. App. 7-11. The Court held also that it would adopt the inapplicable DOL regulation as a guideline for determining if deference properly was accorded. Judge Kennedy dissented, noting:

> If there were a reason to believe that personal examination would enable a treating doctor to better assess the possibility that two conditions were causally connected, then reliance on Dr. Blue's conclusion would be reasonable. But the

> ALJ gave no such reason. *See Peabody Coal Co. v. McCandless*, 255 F.3d 465, 468 (7th Cir. 2001). Further, Dr. Blue's opinion and treatment notes contain no objective support for his . . . theory.

App. 15.

Peabody petitioned for rehearing to ask the Court to overrule *Tussey*, which stood alone as the only case mandating some kind of treating doctor preference in the adjudication of black lung claims.

The court of appeals denied rehearing on April 12, 2002, with Judge Kennedy dissenting. App. 1. This petition followed.

D. The Rulemaking

In 1994, Congress considered and refused to enact a treating doctor rule among many other proposed amendments to the BLBA.[4] In 1997, DOL proposed by regulation much of the rejected legislation, including a treating doctor preference. 62 Fed. Reg. 3339 (Jan. 22, 1997). No physician or scientist testified in support of the treating doctor rule and many urged DOL not to adopt it pointing to its scientific invalidity. DOL republished the rule in 1999,[5] and specifically requested the views of the medical community on how to craft a treating doctor rule.

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[4] *See* H.R. 4415 § 3(4), 103d Cong. 2d Sess. (1994); S.1781, § 3(4), 103d Cong. 2d Sess. (1994). Both provisions accorded "substantial weight" to the treating doctor over the opinions of other physicians if the doctor was board-certified in the relevant specialty. Congress had no medical or scientific information justifying these proposals.

[5] The first proposal failed to comply with the Small Business Regulatory Enforcement Fairness Act, 5 U.S.C. § 605(b).

64 Fed. Reg. 54976. Again, the medical community did not support the rule. On January 19, 2001, the treating doctor rule became effective.

An industry group and others challenged the facial validity of the treating doctor rule and its retroactive application to pending claims, among other things. They argued that the treating doctor rule was impermissibly retroactive in its application to pending claims and violated 5 U.S.C. §§ 556(d), 559, by distorting the significance of certain medical evidence and improperly exaggerating the proper weight due to a treating doctor's opinion. The rule operated as a de facto presumption of the greater credibility of a treating doctor's opinion by according automatic evidentiary significance to the physician's status in violation of *Greenwich Collieries*, 512 U.S. 267, and *Metropolitan Stevedore Co. v. Rambo*, 521 U.S. 121, 137 n.9 (1997). Indeed, DOL noted in the Preamble to the final rule in response to comments asking for the codification of the "true doubt" rule struck down in *Greenwich Collieries*, that the treating doctor rule would accomplish a similar objective. 65 Fed. Reg. 79926 (Dec. 20, 2000). The U.S. District Court for the District of Columbia rejected all challenges to the new rules. *National Min. Ass'n v. Chao*, 160 F. Supp. 2d 47 (D.D.C. 2001).

The D.C. Circuit reversed in part and affirmed in part, holding that the new rules could not be applied retroactively, but that the new treating doctor rule was not retroactive. The court of appeals held that none of the circuit decisions addressing the treating doctor issue was at odds with the new regulation and all of them, including this case, simply repudiated any "automatic" or mandatory preference for the treating doctor's opinion. *NMA*, 292 F.3d at 861-62. Quoting from the Seventh Circuit's opinion in

McCandless, 255 F.3d at 469, the D.C. Circuit assumed that a treating physician's opinion would be given more weight than other medical opinions only if it was "better reasoned," and the adjudicator's decision to accord more credit was supported by a "medical reason." *NMA*, 292 F.3d at 861.

The D.C. Circuit held that the rule does not violate *Greenwich Collieries* or presumptively credit the treating doctor's opinion. *Id.* at 870-71. Addressing the argument that the rule treats treating doctor evidence more favorably in violation of 5 U.S.C. § 559, the court of appeals simply denied it, noting that the rule contained limitations on the ability of an ALJ to give "controlling weight" to a treating doctor's opinion. *Id.* at 870. Finally, the court of appeals considered the complete absence of scientific support for the notion that a treating doctor would gain special medical insight by having treated a miner, in light of the well-documented likelihood that treating doctors were inclined to deceive the factfinder to help a patient. The court of appeals noted that any party-affiliated physician might be dishonest and that DOL did not need any medical or scientific support in the record for its rule, citing *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 51-54 (1983).

If the D.C. Circuit were correct, there would be no need for a treating doctor rule. The strongest and best medical evidence would control the outcome of claims adjudications whether given by the treating doctor or someone else. The reality, however, is that there is a treating doctor rule, it enhances the weight of the treating doctor's opinion without any medical justification, and it is applied unpredictably to support an award of benefits to

claimants who have not been able to prove their claims with the best evidence.

The new regulation and the Sixth Circuit's rule are outcome-determinative rules of enormous power. That power is not authorized by law or justified by science.

The Sixth Circuit and the Department are trying to hide an elephant in the room. The trick simply does not work.

REASONS FOR GRANTING THE WRIT

A. The Courts of Appeals Opinions Cannot Be Reconciled

In the Fourth and Seventh Circuits, a physician's status as a treating doctor is an irrelevant factor in determining the credibility and weight that will be accorded to a medical opinion. Both courts impose a gatekeeper obligation on the factfinder to conduct whatever inquiry is necessary to ensure that facts resting upon scientific or medical information are determined on the basis of the strongest medical or scientific information available. "Agencies relax the rules of evidence because they believe that they have the skill needed to handle evidence that might mislead a jury. . . . They have a corresponding obligation to use that skill when evaluating technical evidence." *McCandless*, 255 F.3d at 468-69, citing *Daubert v. Merrill Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 593 (1993); *Weisgram v. Marley Co.*, 528 U.S. 440, 445 (2000). *Accord*: *U.S. Steel Mining Co., Inc. v. Director, OWCP*, 187 F.3d 384, 389 (4th Cir. 1999).

In the absence of medical or scientific support for the proposition that a treating doctor's status enhances that

doctor's insight into the medical elements of a black lung claim, there is no medical reason and thus no permissible legal reason to give the treating doctor's opinion any additional weight. The Fourth and Seventh Circuits do not do so. In *McCandless*, the ALJ credited a treating physician's opinion over better-credentialed experts assuming that "treating physicians are (by definition) familiar with patients' medical condition during life." 255 F.3d at 470. The Court of Appeals reversed, holding:

> "[I]t is irrational to prefer the opinion of the treating physician, who is often not a specialist, over the opinion of a nontreating specialist solely because one physician is the treating physician." . . . Treating physicians often succumb to the temptation to accommodate their patients (and their survivors) at the expense of third parties such as insurers, which implies attaching a discount rather than a preference to their views.
>
> The alj must have a medical reason for preferring one physician's conclusion over another's. . . . [The treating doctor's] beliefs must be supported by medical reasons if they are to be given legal effect.

McCandless, 255 F.3d at 469-70 (citations omitted). The court of appeals consistently has refused to accord any weight to the status of the treating or examining physician. *See Consolidation Coal Co. v. OWCP*, 54 F.3d 434, 438 (7th Cir. 1995); *Amax Coal Co. v. Beasley*, 957 F.2d 324, 327 (7th Cir. 1992); *Peabody Coal Co. v. Helms*, 901 F.2d 571, 573 (7th Cir. 1990). The Seventh Circuit has not affirmed an ALJ's decision according significant weight to a physician's treating doctor status, and has not disturbed a denial of benefits because insufficient consideration was given to the treating doctor.

The Fourth Circuit's holdings are similar. Relying on Seventh Circuit authority, the Fourth Circuit held:

> Neither this circuit nor the Benefits Review Board has ever fashioned either a requirement or a presumption that treating or examining physicians' opinions be given greater weight than opinions of other expert physicians.

Sterling Smokeless Coal Co. v. Akers, 131 F.3d 438, 441 (4th Cir. 1997) (citations omitted). The Court vacated an award of benefits on this basis noting "[I]n reaching its conclusion, the ALJ ignored the qualifications of the respective physicians, the explanation of their medical opinions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses." *Id.* at 441. The Fourth Circuit has not granted an appeal by a claimant predicated on the theory that insufficient weight was given to a treating doctor because of the doctor's status nor has the court upheld a decision to credit a physician based upon status. The Third Circuit, noting a difference of opinion between the Sixth and Seventh Circuits over the significance of treating doctors' opinions, held that an ALJ should not credit a conclusory opinion by a treating physician. *Lango v. Director, OWCP*, 104 F.3d 573, 577 (3d Cir. 1997).

The Sixth Circuit's decisions stand in stark contrast. The Sixth Circuit insists that its rule is not a "presumption" or an "automatic" preference as if the linguistic designation mattered to the character or legal validity of the rule. It does not matter and the Sixth Circuit's rule, whatever it is called, authorizes, if not requires, an ALJ to give more weight to the treating doctor's opinion. How much more depends upon how much is needed to change the outcome of the case and to shift the balance of the evidence to ensure that it conforms to the treating doctor's opinion.

The rule announced in *Tussey* is not ambiguous: "It is clearly established that opinions of treating physicians are entitled to greater weight than those of non-treating physicians." *Tussey*, 982 F.2d at 1042. In *Groves*, the Sixth Circuit applied the rule with a vengeance to find that Groves had pneumoconiosis and died due to it. These two questions of medicine are not capable of visualization. There is no conceivable theory that treating Groves endowed the treating doctor with superior insight into the cause of death or the presence of occupational lung disease and nothing in the record or common experience suggests otherwise.

Nevertheless, the court of appeals held that *Tussey* requires that more weight be given to a treating doctor, that this is not a presumption and that ALJs should be guided by DOL's treating doctor regulation when applying the *Tussey* rule. App. 7-8. The court of appeals then held that the ALJ had legally sufficient reasons to credit the treating doctor on the cause of Groves's death over two pulmonary specialists, i.e., the treating doctor "had personally examined Groves" and the expert opinions were less credible because "they had failed to find evidence of pneumoconiosis in the first place." App. 11. The court provided no response to the theory the Seventh Circuit expressed in *McCandless* – that the first reason is circular and purely a restatement of the preference. *McCandless*, 255 F.3d at 470-71. In *Groves*, the second "reason" is circular as well since the ALJ found pneumoconiosis to be present solely because of a treating doctor preference in an earlier opinion. App. 65.

The ALJ had no medical or even an evidentiary reason for crediting the treating doctor but the court of appeals found the approach was valid under its treating doctor rule.

The court of appeals then essentially refused to conduct a substantial evidence review. In response to Peabody's argument that the treating doctor's opinion was "conclusory, gratuitous and supported by no valid medical data or identified observations," the court of appeals simply found the treating doctor more credible. As Judge Kennedy notes in her dissent, the majority refused even to look at the record to test whether the credibility judgment was supported by anything more than a treating doctor preference. App. 13. The dissent notes that the record contained no objective support for the treating doctor's causation theory and that "dismissing the opinions of [the pulmonary specialists], as the ALJ did, because they did not personally examine the patient or because they did not believe that Groves suffered from pneumoconiosis misses the point." App. 14-15. Having adopted a sliding scale of additional weight for treating doctors' opinions, the rest of the record is not especially relevant after the treating doctor has spoken.[6]

In *Gray v. Peabody Coal Co.*, 2002 WL 655448, the court of appeals revealed more of its rule.[7] There, the ALJ found the treating doctor's opinion to be reasoned and documented on its face, but not credible in light of the record as a whole. The judge denied benefits because the

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[6] Professor Kenneth Culp Davis in his administrative law treatise notes: "The treating physician rule is totally inconsistent with the substantial evidence test." Davis and Pierce, *Administrative Law Treatise* § 11.3 at 199 (3d ed. 1994).

[7] Although unpublished, *Gray* is prominently featured on the DOL's ALJ website, http://www.oalj.dol.gov/public/blalung/refrnc/blnw042002. htm#black%20lung.

medically stronger evidence proved that Gray's claim was not meritorious. The court of appeals held:

> [W]here the ALJ determines, as in the present case, that the treating physician's opinion is credible, the ALJ must give more weight to the treating physician's opinion than to those of non-treating physicians.
>
> . . . It was error, under these circumstances, not to give additional weight to the opinion of Dr. Simpao, based on his status as treating physician. . . . Where the ALJ determines that the treating physician's opinion is well reasoned and well documented, the ALJ must give more weight to that opinion than to those of other physicians, even where those other physicians have superior qualifications.
>
> On remand the ALJ must reweigh the evidence after giving the opinion of Dr. Simpao additional weight based on his status as Gray's treating physician.[8]

Id. at * 3.

This decision establishes an automatic preference or *per se* rule based solely on the status of the treating doctor. The court of appeals' repeated denials of any intent not to do so are curious at best.

More recently, in *Wolf Creek Collieries v. Director, OWCP*, ___ F.3d ___, 2002 WL 1769282 (6th Cir. Aug. 2, 2002) ("*Stephens*"), the employer appealed from an award in which the ALJ gave conclusive weight to a treating doctor whose principal report was written before a

[8] The treating physician referred to, Dr. Simpao, never treated Gray but merely conducted annual physical examinations.

treating relationship began. All of the objective tests relied upon by this "treating" doctor were discredited, the doctor understated the miner's smoking habit by at least 50 pack/years and the doctor made no attempt to document his findings with medical data.

After repeating the proposition that the court of appeals had no presumption or automatic rule, the court observed that the ALJ properly discredited the DOL expert and employer's experts because they did not examine Stephens. *Id.* at ** 7-9. On "substantial evidence" review, the court of appeals noted that it would not re-evaluate the ALJ's credibility determinations. *Id.* at * 10.

There are no published or unpublished decisions in which the Sixth Circuit disturbed an ALJ's treating physician preference. There are published and several unpublished decisions in which the Court affirmed an ALJ's refusal to apply an automatic preference.[9] It is certain, however, that the court of appeals accorded more weight to a treating doctor's opinion solely because of the doctor's status. It is certain that the application of the Sixth Circuit's treating doctor rule impedes or prevents substantial evidence review. *See* Davis, *supra*, n.6; *Canavan's Case*, 432 Mass. 304, 314, 733 N.E.2d 1042 (Mass. 2000).[10] It is apparent as well that an ALJ deciding a black

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[9] *See Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995). There are over twenty unpublished decisions that predate the decision in *Groves*. They are ambiguous and provide no guidance.

[10] In *Canavan's Case*, the Supreme Judicial Court of Massachusetts rejected a workers' compensation rule excusing a treating doctor's opinion from an analysis of its scientific reliability required for other expert opinions in Massachusetts claims. There, the court below held that "clinical experience and personal observation, merited an exception to the general rule of reliability," thus minimizing appellate scrutiny.

(Continued on following page)

lung claim in the Sixth Circuit is not required to base an opinion on the best or strongest or most credible medical evidence if the treating physician has spoken.[11]

That is not the law in the Fourth or Seventh Circuits.

B. There is No Legal or Scientific Foundation For Giving More Weight to a Treating Doctor

The DOL rulemaking brings enlightenment to the issue. The American College of Chest Physicians commented:

> We agree that some opinions should be considered to carry more weight than others. Opinions that carry the most weight should be based on the competence of the physicians and the competence of the opinion that was written. Everything else (the duration of the relationship between the doctor and the miner or the extent of the treatments) is irrelevant. This is an important error in the proposed regulations which must be corrected in this amended version of the black lung regulations.

Exhibit 5-165 to Proposed Rulemaking ("Comments on Proposed Rule: Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended" (Aug. 20, 1997)). The Occupational Lung Disorder

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The supreme court reversed, holding that a treating doctor's testimony could be considered only "[I]f the proponent can show that the method of personal observation is either generally accepted by the relevant scientific community or otherwise reliable to support a scientific conclusion relevant to the case. . . . " *Canavan's Case*, 432 Mass. at 314.

[11] In defending its regulation, DOL argued that the treating doctor rule is not mandatory. *See NMA*, 292 F.3d at 861. That is neither true in the Sixth Circuit nor a valid defense of the regulation.

Committee of the American College of Occupational and Environmental Medicine also opposed the preference:

> The treating physician, however, has an inherent conflict of interest in determining whether the coal miner patient is totally disabled from pneumoconiosis due to coal mine dust exposure. By supporting their patient's claim for black lung benefits, the treating physician is helping to guarantee future reimbursement for medical services rendered by the treating physician for almost any type of pulmonary disorder in ensuing years based on the proposed amendments to the Black Lung Benefits Act. This represents a direct financial conflict of interests. The eligibility determination for Black Lung Benefits should be done as independent medical evaluations by physicians with extensive experience and training in occupational pulmonary disease. The treating physician's medical records and supportive documentation should be available for review by the independent medical examiners and taken under consideration when rendering their opinions. The treating physician's opinion can be counted as a pulmonary evaluation but should be given equal and not controlling weight in determining whether a coal miner is totally disabled or died due to pneumoconiosis.

Exhibit 5-166 to Proposed Rulemaking (Comments Regarding the DOL Proposal to Amend Regulations Implementing the Black Lung Benefits Act (Aug. 21, 1997)). Recent research into whether treating doctors would use deception to assist patients in obtaining third party paid benefits confirms these concerns. V. Freeman, *et al.*, "Lying

for Patients: Physician Deception of Third-Party Payers," 159 *Archives of Internal Med.* 2263 (Oct. 25, 1999).[12]

Drs. Ben Branscomb and William Bailey, both Professors of Pulmonary Medicine, commented:

> We feel it is bad science to impose upon the adjudicator regulations that mandate giving controlling weight to the treating physician. In everyday practice, physicians evaluate numerous medical reports and weigh different physicians' opinions depending on the question that is being asked and the scientific quality of the answer. We see no reason why medical questions for coal miners should be adjudicated differently.

Exhibit 5-174: App. 8 at 13-14, Comments of the National Mining Assn., *et al.* (Aug. 21, 1997). Dr. Branscomb further testified:

> . . . I think that to assign particular weight to someone called the treating physician is artificial and is going to interfere with the objectives of the department in getting the right information out. . . . [T]he doctor's opinion ought to stand on

[12] Dr. Freeman found that 76.4% of physicians felt it was proper to advocate for their patients and if necessary to be deceptive in helping patients obtain third party paid benefits. *See also* W. M. Sage, "Physicians as Advocates," 35 Hous.L.Rev. 1529 (1999); Kevin F. Foley, "Physician Advocacy and Doctor Deception," 48 The Fed. Lawyer 25 (July 2001). Foley notes that SSA's treating doctor rule creates invalid data and may force unnecessary and inappropriate treatment. *See also* Dennis H. Novack, M.D., *et al.*, "Physician Attitudes Toward Using Deception to Resolve Difficult Ethical Problems," 261 J. Am. Med. Assn. 2980 (1989) (observing that 85% of treating doctors believe that deception is justified because of unreasonable insurance requirements and because patient interests have priority).

> itself, not on some designation that he's a treating physician.

Exh. 35 (Branscomb Tr. at 42, 43).

Another pulmonary physician commented:

> The Department's proposal to give opinions from treating doctors "controlling" weight is a departure from sound medical practice. . . . Doctors do not evaluate medical reports or opinions based on the status of the doctor, they weigh different opinions based on the question that is at issue and the underlying support both in the science and in the studies conducted. There simply is no scientific support for the Department's proposal that treating doctors are in a better position to diagnose pneumoconiosis or determine both the extent and cause of a patient's impairment.
>
> * * *
>
> Frequent contact alone provides no advantage. The mere fact of treatment of a miner's general health is medically irrelevant if the doctor does not have the basic skills or has not performed the relevant tests. The quality of an opinion by a treating doctor, an examining doctor, or a consultant on questions of impairment depends on the special training, skill, and expertise of the doctor and the availability of objective tests of lung function that can be validated according to published standards by a qualified pulmonary physician. . . . There is no medical rationale to automatically give more weight to a treating physician in the evaluation of a miner's pulmonary status.

Exh. 89-37: App. C (Greg Fino, M.D., *et al.*, "Comments on the Medical and Scientific Issues Presented in the Department of Labor's Proposal dated October 8, 1999").

In the final rule, DOL chose simply to reject the comments. The agency articulated no rationale in support of its rule opting instead to argue in the Federal Register Preamble that the rule was not as bad as commentators believed and that it had safeguards to prevent its interpretation as an automatic preference. 65 Fed. Reg. 79930-35 (Dec. 20, 2000). Whether DOL's rule or the Sixth Circuit's rule, the treating doctor rule assumes medical facts about the evidentiary value of a treating doctor's opinion. It is rule of science that is unsupported by any science. It is not the product of any congressional inquiry or statutory mandate. The rule is plainly arbitrary and capricious within the meaning of 5 U.S.C. § 706. *State Farm*, 463 U.S. at 42-43.[13]

In assuming without proof that the treating doctor is better informed, the burden of persuasion on the credibility of a party's expert is shifted from the proponent of the evidence to the adverse party in violation of *Greenwich Collieries*, 512 U.S. at 280 (holding DOL has no authority to "decide who shall bear the burden of persuasion" in a manner that conflicts with the APA). Neither does the court of appeals have the authority to do so. There is no doubt that both the court of appeals and DOL have adopted a rule that is incompatible with the APA. *See also Rambo*, 521 U.S. at 137 n.9.

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[13] The D.C. Circuit in NMA held that DOL needed no record to support the rule, treating it as a pure policy judgment entrusted to the agency. *NMA*, 292 F.3d at 870-71. The adoption of a rule of science is not a policy judgment left to an agency. It must be supported and this one is not. There is no rationale for giving more weight to one type of expert in the absence of justification.

The treating doctor rule artificially exaggerates the weight to be accorded certain evidence without valid reason. The court of appeals seeks to force ALJs to draw an inference of superior insight of treating physicians and has no valid basis for doing so. DOL's regulation as it is applied here by the court of appeals and as it is interpreted by DOL[14] seeks the same objective. In either case, this distortion of the factfinding process in an APA proceeding is prohibited by this Court. *Allentown Mack*, 522 U.S. at 377-78; *see also Ragsdale v. Wolverine World Wide, Inc.*, 122 S. Ct. 1155 (2002) (disapproving categorical or *per se* rules that fail to hold true in the great majority of cases).

The treating doctor rule, whether it is the powerful result-oriented rule of the court of appeals, or the DOL regulation that is larded with mostly irrelevant inquiries to the same effect, serves only to downgrade the principles of impartiality and fair play that parties expect in litigation. It distorts and manipulates the factfinding process to produce an unjustified result at trial and then impedes normal substantial evidence review, at least according to the Sixth Circuit's usage, by preventing any inquiry into whether the invocation of the rule by the factfinder was justified.

The court of appeals never has articulated a justification for its rule and confronts claims of inconsistency with the APA and principles of substantial evidence review with

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[14] The rule also conflicts with 5 U.S.C. § 559, to the extent it prohibits "requirements or privileges relating to evidence or procedure" that apply unequally. The claimant is almost always the party offering the treating doctor's opinion and a rule favoring treating doctors is not a rule that applies equally.

simple denials. The rule is intended to produce unfair adjudication and that is precisely what it accomplishes.

The Veterans Administration has rejected a treating doctor rule noting that it is inappropriate as a medical matter in determining service relatedness. *White v. Principi*, 243 F.3d 1378, 1381 (Fed. Cir. 2001). A majority of the courts of appeals have rejected a treating doctor preference in disputes arising under the Employee Retirement Income Security Act, 29 U.S.C. § 1001, *et seq.* ("ERISA").[15] The Ninth Circuit accepted without proof or documentation the premise that treating doctors have superior insight. Relying on an SSA disability rule for this conclusion, and reasoning that since both ERISA and the Social Security Act are federal statutes, the court, with one judge dissenting, held that the SSA treating doctor rule should apply in ERISA cases. *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1139 (9th Cir. 2001). The court of appeals attempted to distinguish the principal contrary authority,[16] noting that those cases involved health care disputes not disability determinations.[17] The distinction has not held. The Second and Eleventh Circuits have rejected application of a treating

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[15] The Sixth Circuit in an unpublished decision has held: "A treating physician's opinion is not entitled to greater weight in an ERISA context." *Jackson v. Metropolitan Life*, 24 Fed. App. 260, 2001 WL 1450811 at * 2 (6th Cir. 2001).

[16] *See Elliott v. Sara Lee Corp*, 190 F.3d 601 (4th Cir. 1999); *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011 (5th Cir. 1992); *Jett v. Blue Cross and Blue Shield of Ala., Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989).

[17] DOL's regulations apply a treating doctor preference for health care disputes as well as disputes over diagnosis, disability and causation. *See* 20 C.F.R. § 725.701(d).

doctor rule in disability determinations. *Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002); *Connors v. Connecticut Gen. Life Ins. Co.*, 272 F.3d 127, 136 n.4 (2d Cir. 2001).

For Social Security disability claims, the Second Circuit adopted a strong judge-made preference for treating doctors that was curtailed substantially by an SSA regulation intended to limit the Second Circuit's rule. *See Schisler v. Sullivan*, 3 F.3d 563, 567-8 (2d Cir. 1993).[18] In developing its own rule and then upholding SSA's more restrictive rule, the Second Circuit relied on the unsubstantiated assumption that a treating doctor's status justified significant weight. *Id.* Both SSA and the Second Circuit have rejected a treating doctor preference for Medicare claims, although the court of appeals would leave open the possibility that it might apply in the future. *Keefe v. Shalala*, 71 F.3d 1060, 1064 (2d Cir. 1995). The Department of Health & Human Services also has rejected a treating doctor rule in claims under the National Childhood Vaccine Injury Act. 42 U.S.C. § 300aa-1 (1998). *Stevens v. Sec'y of HHS*, 2001 WL 387418 at * 16 (Fed. Cl. 2001).

No treating doctor rule has gained a foothold under the LHWCA. The majority of states have rejected a treating doctor preference for their workers' compensation programs, but a few have adopted a preference. *See Conradt v. Mt. Carmel School*, 197 Wis.2d 60, 69-72 (Wis. Ct. App. 1995) (surveying state laws); *Jenkins v. Workmen's*

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[18] SSA's rules are at 20 C.F.R. §§ 404.1527(d) (2002) and 416.927(d) (2002).

Comp. Appeal Bd., 677 A.2d 1288, 1293 (Pa. Commw. Ct. 1996).

One thing is common to all applications of a treating physician rule, whether it is an automatic requirement that the treating doctor receive more weight or a more complex formulation. In each case, the rule is sustained solely by an assumption or presumption that the treating doctor will acquire special insight into a patient's health. With respect to diagnosis, differential diagnosis and causation or cause of death, there is no scientific support for the presumption. DOL's rulemaking proved that much.

It is not likely this Court can find a good reason to sustain the Sixth Circuit's or DOL's rule.

C. The Court of Appeals Rule Will Have an Enormous Adverse Impact

Following *Groves*, *Gray*, and *Stephens*, a treating doctor factor will control the outcome in a substantial number of claims. It already has proven to be a factor in the way claimants develop evidence and the way attorneys representing claimants develop their cases. The rule is an outcome determinative force that the court of appeals has no apparent intent to control and it will certainly spin out of control, affecting thousands of cases in Kentucky, Tennessee and Ohio.

This is the assumption of actuaries and state rating organizations that reviewed the more modest rule proposed by DOL. Extensive actuarial analyses were performed in the course of the DOL rulemaking and in those analyses, the treating doctor rule was identified as a

significant factor in increasing claims filings and the overall approval rate of claims.[19] What is more important is that all of the most significant changes in DOL's new regulations are reflected in amended and relaxed medical eligibility criteria. *See NMA*, 292 F.3d at 868-72. The treating doctor rule requires the ALJ to give more weight to the treating doctor's fairly predictable opinion with respect to the new medical criteria.

Those criteria, including the treating doctor rule, are the principal driving force behind huge insurance rate increases, distortions in insurance markets, predictions of dramatically increased liabilities and the eventual loss of up to 25,000 coal mining jobs in the small operator segment of the industry.[20]

This effect is responsible for rate increases of more than 200% in most states,[21] and a disappearance of the voluntary market for workers' compensation insurance for mine operators. The cost of insurance in that market may be as much as 30% below the coverage provided by state or

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[19] In oral argument before the D.C. Circuit, the Secretary acknowledged that its revised rules would result in an increase in liability due to "only a few of the particular regulations" and named the treating physician rule. Transcript of Proceedings at 58-62, *NMA*, 292 F.3d 849 (No. 01-5278).

[20] Comments of Robert Briscoe, Senior Consultant, Milliman & Robertson, Exh. No. 89-37, App. A (Dec. 1999). Briscoe predicts that the rules and related litigation will have a cost of from $3.3-7.1 billion based on an expected doubling of claims approval rates, increased filings and substantially increased medical care costs. Exh. No. 5-174, Ex. 5, Exh. Nos. 5-137, 35 at 86-88. DOL's consultant predicted a 66% increase in benefit awards and a 39% increase in insurance costs. *NMA*, 292 F.3d at 855.

[21] Kentucky and Tennessee have approved insurance rate increases of from 212-270% for federal black lung coverage.

national high risk pools. *See supra* n. 20. The treating doctor rule is, of course, not the sole reason for these additional costs, but it bears proximally and significantly on all the reasons for these economic consequences. It will be worse than predicted for operators in the Sixth Circuit.

Neither does a strong treating doctor rule have beneficial effects for the workers' compensation system and health care delivery to beneficiaries. In 1993, the California legislature adopted a limited treating doctor presumption for workers compensation claims with the intent to streamline and simplify claims litigation. The California courts expanded the rule to the point that the treating doctor's opinion "on all medical issues was nearly irrebuttable, making it almost impossible for claims administrators to terminate unreasonable, unnecessary, excessive or incompetent care." Gardner and Swedlow, "California Workers' Compensation Medical Payments, Litigation and Claim Duration – A Post-Reform Report Card," California Compensation Inst. Research Notes (May 2002). This study of the California rule disclosed that it caused significant increases in claims litigation rates, the duration of claims adjudication, increased medical treatment costs, total claims costs, medical-legal costs and claims frequency. *Id.* at 7. Legislation to significantly limit California's rule was adopted in February 2002. Cal. Assembly Bill 749, Legislative Counsel's Digest § 18 (2002).

Other commentators have remarked on the adverse consequences a treating doctor rule may have for patients, employers, health care providers and benefit delivery systems alike. *See* B. Sheehy, "An Analysis of the Honorable Richard A. Posner's Social Security Law," 7 Conn. Ins. L.J. 103, 127-28 (2001) (noting a "real world" likelihood

that treating doctors "lean over backwards" to help patients); R. Prentice, "The SEC and MDP: Implications of the Self-Serving Bias for Independent Auditing," 61 Ohio St. L.J. 1597, 1621-22 & n.120 (2000) (documenting physician behavior where the physician has enhanced control over treatment and diagnosis of patients); R. Schneider, "A Role for the Courts: Treating Physician Evidence in Social Security Disability Determinations," 3 U.Chi. L. Sch. Roundtable 391, 412-13 (1996) (conflicting roles for treating physicians impede ability to provide quality care).

The sole justification articulated for a treating physician rule is false and it has been refuted by persuasive medical authority. The rule stands now as a purely arbitrary mandate that forces artificial and incorrect results in claims adjudications. There is no window dressing that improves the rule and, as demonstrated by the Sixth Circuit's decision in this case, *Gray* and *Stephens*, the rule's sole function is to enhance the weight of the poorest and weakest evidence. This rule has no proper role in the adjudication of private liabilities.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

MARK E. SOLOMONS
Counsel of Record
LAURA METCOFF KLAUS
GREENBERG TRAURIG LLP
800 Connecticut Ave., N.W.
Washington, D.C. 20006
(202) 533-2361

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UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

PEABODY COAL CO.,

Petitioner,

v.

WILMA J. GROVES; DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR,

Respondents.

On Appeal from the United States Department of Labor, Benefits Review Board.
No. 99-0341 BLA.

Argued: December 4, 2001

Decided and Filed: January 17, 2002

Before: KENNEDY, MOORE, and COLE, Circuit Judges.

COUNSEL

ARGUED: Mark E. Solomons, GREENBERG & TRAURIG, Washington, D.C., for Petitioner. Helen Cox, UNITED STATES DEPARTMENT OF LABOR, OFFICE OF THE SOLICITOR, Washington, D.C., Joseph H. Kelley, MONHOLLON & KELLEY, Madisonville, Kentucky, for Respondents. **ON BRIEF:** Mark E. Solomons, Laura Metcoff Klaus, GREENBERG & TRAURIG, Washington, D.C., for Petitioner. Helen Cox, Patricia M. Nece, UNITED STATES DEPARTMENT OF LABOR, OFFICE OF THE

SOLICITOR, Washington, D.C., Joseph H. Kelley, MONHOLLON & KELLEY, Madisonville, Kentucky, for Respondents.

MOORE, J., delivered the opinion of the court, in which COLE, J., joined. KENNEDY, J. (pp. 12-13), delivered a separate dissenting opinion.

OPINION

KAREN NELSON MOORE, Circuit Judge. Petitioner Peabody Coal Co. ("Peabody") appeals an award of benefits under the Black Lung Benefits Act ("BLBA"), 30 U.S.C. §§ 901-962. Peabody argues 1) that the administrative law judge ("ALJ") applied a "treating physician presumption" in violation of the Administrative Procedure Act, 5 U.S.C. §§ 551-559, and 2) that the ALJ's decision to rely on the treating physicians' medical opinions was irrational. Because Peabody's arguments lack merit, we AFFIRM the benefits award.

I. BACKGROUND

On April 30, 1995, sixty-year-old Elze Groves ("Groves") died in the emergency room of Ohio County Hospital. His death certificate identified the cause of death as cardiac arrest due to acute myocardial infarction and arteriosclerotic heart disease. Groves had worked underground in coal mines for over thirty-three years. On May 11, 1995, his widow Wilma Jean Groves ("Wilma") applied for black

lung survivor's benefits under the BLBA.[1] On May 1, 1996, a district director of the Office of Workers' Compensation Programs ("OWCP") of the United States Department of Labor ("DOL") affirmed a previous finding that the evidence failed to establish that Groves had suffered from or died as a result of pneumoconiosis. The DOL identified Peabody as the responsible coal mine operator and notified it of the pending claim.

At Wilma's request, the case was forwarded to the DOL Office of Administrative Law Judges for a hearing, which was held on April 29, 1997. On June 30, 1997, the ALJ denied Wilma's claim. He first found that Groves had suffered from pneumoconiosis, giving the most weight to the opinions of Drs. Robert T. Johnson ("Johnson") and W.B. Blue ("Blue"),[2] which were "supported by the well-documented and well-reasoned reports" of several other doctors who had examined Groves. Joint Appendix ("J.A.") at 37-38. However, the ALJ found that the evidence did not establish that Groves's death was hastened by pneumoconiosis:

> Only Dr. Blue opined that [Groves's] death was hastened by pneumoconiosis. However, I find that Dr. Blue's opinion is outweighed by the well-reasoned and well-documented opinions of Drs. Branscomb and Fino. To the contrary, Dr. Blue's

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[1] Groves himself filed an application for benefits on November 7, 1988, which was denied on May 2, 1989. Groves did not appeal this decision.

[2] Drs. Johnson and Blue were Groves's treating physicians. Dr. Johnson was Groves's personal physician for approximately fifteen years, from 1973 to 1988. Dr. Blue treated Groves from 1987 until Groves's death.

> opinion regarding the factors contributing to [Groves's] death is not well-documented. An undocumented opinion may be given little or no weight.

J.A. at 38 (citations and footnote omitted).[3] Wilma filed a timely notice of appeal with the Board. On July 14, 1998, the Board affirmed the ALJ's finding of pneumoconiosis but vacated his finding about Groves's cause of death and remanded the case for further consideration. The Board noted that the ALJ had described Dr. Blue's opinion as "undocumented" but failed to consider Dr. Blue's treatment notes, as he should have in determining the physician's credibility. J.A. at 24.[4]

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[3] Dr. Ben V. Branscomb ("Branscomb") issued a consultative report dated August 23, 1996, in which he concluded "[w]ith a high level of medical certainty" that Groves did not suffer from pneumoconiosis. J.A. at 78. He attributed Groves's death to coronary artery disease, which he claimed "was in no way caused, hastened, [ ]or ... aggravated by pulmonary disease or by coal mine dust exposure." J.A. at 78. He then stated, "Although [Groves] has no [pneumoconiosis], if I assume he did, there would still be no reasonable basis for attributing any aggravation, contribution to, or acceleration of his death as a result of such pneumoconiosis." J.A. at 78.

Dr. Gregory J. Fino ("Fino") issued a consultative report dated September 4, 1996, in which he concluded with "a reasonable degree of medical certainty," J.A. at 81, that Groves did not suffer from pneumoconiosis and that his "death was due to atherosclerotic heart disease and acute myocardial infarction. Coal mine employment did not cause, contribute to, or hasten his death." J.A. at 93.

[4] Dr. Blue was not the attending physician at Groves's death. His treatment notes, therefore, do not cover the immediate cause of Groves's death. However, they were relevant to the ALJ's analysis to the extent that they addressed the factors that may have hastened Groves's death. *See Griffith v. Dir., OWCP*, 49 F.3d 184, 186 (6th Cir. 1995) ("A claimant establishes that pneumoconiosis is a substantially

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On November 24, 1998, the ALJ issued a decision and order awarding survivor's benefits to Wilma. In finding on remand that Dr. Blue's opinion about Groves's cause of death was "the most credible," J.A. at 19, the ALJ referred to Dr. Blue's treatment notes, which recorded that Dr. Blue had treated Groves for breathing problems from 1987 to 1994. J.A. at 15-16. The ALJ then quoted verbatim a report submitted by Dr. Blue on February 2, 1996, that opined:

> Groves was a product of many years in the mines with the primary lack of oxygenation to his tissues speeding his death significantly. His immediate cause of death was the coronary artery disease which was largely a result of the chronic low oxygen assaturation superimposed on his metabolic abnormalities of sugar and lipids. It is my opi[ni]on that his pneumoconiosis was probably a third to a half responsible for his final demise.

J.A. at 16-17. The ALJ specifically found that Dr. Blue's "treatment notes, which show that [Groves's] lung function was impaired, support Dr. Blue's letter of February 2, 1996, and bolster his credibility." J.A. at 18. In contrast, he found that the opinions of Peabody's experts were entitled to less weight because they "failed to find any evidence of pneumoconiosis." J.A. at 18. On December 18, 1998, Peabody filed a timely appeal to the Board from the ALJ's decision.

On December 22, 1999, the Board affirmed the ALJ's decision, observing that the ALJ's decision to accord the

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contributing cause or factor leading to the miner's death if it serves to hasten that death in any way." (quotation omitted)).

greatest weight to Dr. Blue's opinion about Groves's cause of death was rational because Dr. Blue had treated Groves "for a lengthy period of time" and Dr. Blue's conclusion about a decrease in oxygenation to Groves's tissues, which hastened his death, was credible. J.A. at 11. The Board also stated that the ALJ had permissibly accorded less weight to the opinions of physicians who had not examined Groves and who had "ruled out the existence of pneumoconiosis in [Groves], when in fact the presence of the disease had been established." J.A. at 11. Peabody then filed a motion for reconsideration, which the Board denied on May 17, 2000. This timely appeal followed.

II. ANALYSIS

We have a very narrow scope of review over the Board's decisions, which must be affirmed unless the Board has committed legal error or exceeded its scope of review of the ALJ's findings. *Tennessee Consol. Coal Co. v. Kirk*, 264 F.3d 602, 606 (6th Cir. 2001). The ALJ's findings are conclusive if they are supported by substantial evidence and are in accordance with the applicable law. *Id.* Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Cross Mountain Coal, Inc. v. Ward*, 93 F.3d 211, 216 (6th Cir. 1996) (quoting *Richardson v. Perales*, 402 U.S. 389, 401 (1971)). "We do not reweigh the evidence or substitute our judgment for that of the ALJ." *Tennessee Consol.*, 264 F.3d at 606. Thus, we will not reverse the conclusions of an ALJ that are supported by substantial evidence, "even if the facts permit an alternative conclusion." *Id.* (quoting *Youghiogheny & Ohio Coal Co. v. Webb*, 49 F.3d 244, 246 (6th Cir. 1995)).

A. "Treating Physician Presumption"

The survivors of a miner are eligible for benefits under the BLBA if they can prove 1) that the miner had pneumoconiosis, which arose out of coal mine employment, and 2) that the miner's death was due to pneumoconiosis. 20 C.F.R. § 718.205(a). Claimants may satisfy the second requirement by showing that pneumoconiosis was "a substantially contributing cause" of the miner's death. *Id.* § 718.205(c)(2). Peabody argues that "[t]he ALJ found both the existence of pneumoconiosis and death due to it by presuming that the opinion of a doctor who treated the miner was automatically more credible than any other doctor's opinion simply by virtue of that treatment." Petitioner's Br. at 18.

In *Tussey v. Island Creek Coal Co.*, 982 F.2d 1036 (6th Cir. 1993), we confirmed that the "opinions of treating physicians are entitled to greater weight than those of non-treating physicians." *Id.* at 1042. However, we did not suggest that treating physicians should automatically be presumed to be correct – we indicated that their opinions should be "properly credited and weighed." *Id.* Indeed, Peabody concedes as much: "In post-1994 unpublished decisions, however, this Court almost uniformly has recognized that notwithstanding *Tussey*, ALJs are not *required* to credit treating doctors' opinions either standing alone or where there is conflicting proof in the record." Petitioner's Br. at 29.[5] We therefore conclude that Peabody's

[5] We observe that the unpublished decisions that Peabody cites in its brief do not support its position. *See, e.g., Arch of Kentucky, Inc. v. Hickman*, No. 98-3421, 1999 WL 646283, at *4 (6th Cir. Aug. 13, 1999) ("Although the diagnoses of treating physicians are not entitled to

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"treating physician presumption" argument lacks merit and disagree with its characterization of the *Tussey* decision as ambiguous or in conflict with the established caselaw.

Tussey requires ALJs in black lung cases to examine the medical opinions of treating physicians on their merits and to make a reasoned judgment about their credibility. These opinions should be "[g]iven their proper deference." *Tussey*, 982 F.2d at 1042. In determining the level of deference that would be proper, we turn to 20 C.F.R. § 718.104(d)(5), which delineates the criteria for the development of medical evidence in black lung proceedings:

> In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

Id.[6] Given this standard, Peabody's interpretation of the ALJ's decision and order in this case is not tenable. In particular, we observe that the ALJ initially *denied* Wilma's claim, finding that Wilma had failed to establish

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conclusive weight or even a presumption in favor of the Claimant, courts have noted that their opinions deserve 'special consideration.'" (citation omitted)).

[6] Although this provision applies only to evidence developed after January 19, 2001, 20 C.F.R. § 718.101(b), we find it instructive although not directly applicable in this case.

that pneumoconiosis hastened her husband's death.[7] After the Board vacated this finding and remanded the case for further findings with respect to the medical opinion evidence, the ALJ found that Wilma was entitled to survivor's benefits. In his decision and order on remand, the ALJ reviewed Groves's medical records as compiled by his treating physicians and the consultative reports issued by a DOL expert and two Peabody experts. The ALJ discounted the opinion of the DOL expert, who had reviewed a limited amount of the available evidence, as "not well-reasoned." J.A. at 18. The ALJ also accorded less weight to the opinions of Drs. Branscomb and Fino and noted that "[n]either physician ever personally examined" Groves. J.A. at 18. In addition, the ALJ found that the

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[7] In finding that Groves had suffered from pneumoconiosis, which Peabody's experts disputed, the ALJ stated:

> I give the most weight to the opinions of Drs. Johnson and Blue, as buttressed by the opinions of [four other physicians] and several of [Groves's] hospital records. Drs. Blue and Johnson were [Groves's] treating physicians. More weight may be accorded to the conclusions of a treating physician as he is more likely to be familiar with the Miner's condition than a physician who examines him episodically. . . . [A] comparison of medical reports and tests over a long period of time may conceivably provide a physician with a better perspective than th[at of] a non-treating physician. . . . It is proper to accord less weight to a consulting or non-examining physician[ ] on the ground that he does not have first-hand knowledge of the miner's condition.

J.A. at 37-38 (citations omitted). However, in finding that the evidence was insufficient to establish death due to pneumoconiosis, the ALJ concluded that Dr. Blue's opinion, which he characterized as "not well-documented," was "outweighed by the well-reasoned and well-documented opinions of Drs. Branscomb and Fino." J.A. at 38. The ALJ thus did not apply a treating physician presumption in his initial denial of Wilma's claim.

opinions of these two consultants were "less credible" because they did not make a finding of pneumoconiosis, unlike the physicians who had actually examined Groves. J.A. at 18.

The ALJ gave "the most weight" to Groves's treating physicians:

> Their progress reports establish that they treated [Groves] for nearly twenty-five years. [Groves] had problems with his breathing during this time and was diagnos[ed] with, among other things, chronic obstructive pulmonary disease, bronchitis, acute bronchitis, and coal workers' pneumoconiosis. These treatment notes, which show that [Groves's] lung function was impaired, support Dr. Blue's letter of February 2, 1996, and bolster his credibility. . . . Therefore, I find Dr. Blue's letter and treatment notes are persuasive in establishing that [Groves's] death was hastened by pneumoconiosis.

J.A. at 18-19. On appeal, the Board affirmed the ALJ's finding that Wilma had established that her husband's death was due to pneumoconiosis. Specifically, the Board concluded that the ALJ's decision to accord greater weight to Dr. Blue's opinion was rational because Dr. Blue had treated Groves for many years. The Board also noted that the ALJ had not abused his discretion in according less weight to the opinions of Peabody's experts, who had never examined or treated Groves and had "ruled out the

existence of pneumoconiosis in [Groves], when in fact the presence of the disease had been established." J.A. at 11.[8]

It is thus abundantly clear that the ALJ did not give presumptive weight to the opinions of Groves's treating physicians. The ALJ did accord more weight to these opinions than to those of the consultants for the DOL and Peabody, but he examined all of the opinions on their merits and made reasoned judgments about the physicians' credibility. He also reviewed Groves's medical records. We thus conclude that the ALJ did not apply an automatic preference for or presumption in favor of Groves's treating physicians.

B. Substantial Evidence

Peabody argues that the ALJ's decision to rely on the opinions of Groves's treating physicians was irrational because the opinions did not constitute substantial evidence. This argument is based on the following facts: 1) Drs. Blue and Johnson's finding of pneumoconiosis was "not confirmed by better qualified readers" and should

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[8] The OWCP argues that the ALJ's "summary dismissal of the opinions of Drs. Fino and Branscomb for lack of personal examination was simply wrong." Respondent (OWCP)'s Br. at 32-33. However, the ALJ had two reasons for giving less weight to the opinions of Peabody's experts: 1) neither physician had personally examined Groves and 2) their opinions about Groves's cause of death were less credible because they had failed to find any evidence of pneumoconiosis in the first place.

The Board acknowledged in Peabody's second appeal that "Dr. Branscomb concluded that, while [Groves] did not suffer from pneumoconiosis, even if he had the disease it would not have hastened his death." J.A. at 11 n.2. However, it affirmed the ALJ's decision, noting that Dr. Fino had ruled out the existence of pneumoconiosis.

have confuted their credibility because it "was at odds with the ALJ's finding that the x-rays did not establish the disease," 2) Dr. Johnson relied on a pulmonary function study that was invalidated on expert review, 3) Drs. Blue and Johnson failed to mention Groves's smoking history, and 4) Dr. Blue's opinion on the cause of Groves's death was "conclusory, gratuitous and supported by no valid medical data or identified observations." Petitioner's Br. at 34-36.

Peabody cites *Director, OWCP v. Rowe*, 710 F.2d 251 (6th Cir. 1983), and contends that the opinions of Groves's treating physicians were not credible. However, the *Rowe* court expressly observed that the ALJ as factfinder should decide whether a physician's report is "sufficiently documented and reasoned," because such a determination is "essentially a credibility matter." *Id.* at 255. Lacking the authority to make credibility determinations, we will defer to the ALJ's findings. In fact, the Board remanded the case to the ALJ after he denied Wilma's claim because the ALJ had "not specifically address[ed Dr. Blue's treatment notes] in making his credibility determination." J.A. at 24. The issue of Dr. Blue's credibility was thus the primary consideration on remand. The ALJ as factfinder found, based on Dr. Blue's treatment notes, that Dr. Blue's opinion was "the most credible evidence in the record regarding the cause of [Groves's] death." J.A. at 19.[9]

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[9] As the ALJ noted on remand, pneumoconiosis need not be the immediate or proximate cause of death. Therefore, the fact that Groves suffered from heart disease and other medical problems does not affect the import of Dr. Blue's conclusion that pneumoconiosis compromised the function of Groves's lungs and thereby hastened his death.

Peabody now asks us to reach the opposite conclusion, arguing that the facts do not support Dr. Blue's opinion. Such a determination, however, would require us to address Dr. Blue's credibility, which would exceed our limited scope of review over the Board's decisions. We may reverse the ALJ's conclusion only if it is not supported by substantial evidence. Accepting the ALJ's determination of Dr. Blue's credibility, we observe that Dr. Blue attributed Groves's heart disease, which caused Groves's death, largely to "lung disease secondary to pneumoconiosis and a lack of oxygenation." J.A. at 60. Dr. Blue's treatment notes, which indicate that Groves had pulmonary problems, thus provide adequate evidence to support the ALJ's conclusion that Groves's death was hastened in some way by pneumoconiosis. We recognize that the record may permit an alternative conclusion, but we also respect and defer to the ALJ's authority in the finding of facts.

III. CONCLUSION

For the foregoing reasons, we **AFFIRM** the Board's order.

DISSENT

KENNEDY, Circuit Judge, dissenting. Because I disagree with the majority's conclusion that the ALJ's decision was supported by substantial evidence, I would remand. The majority avoids this result by observing that this court has a limited scope of review over the Board's decisions and is not to assess the credibility of Dr. Blue. My decision to remand, however, would not be based on an assessment of Dr. Blue's credibility, but rather on the ALJ's failure to analyze the reasoning of, and support for,

Dr. Blue's conclusion. The ALJ accepted Dr. Blue's conclusion that a lack of oxygenation to Groves' tissues, resulting from pneumoconiosis, contributed to Groves' arterial sclerotic heart disease, and ultimately, to his death. The ALJ found that Dr. Blue's treatment notes and letter supported this conclusion. In weighing the medical evidence, the ALJ gave the most weight to Dr. Blue's opinion because he had personally examined and treated Groves for nearly twenty-five years. Yet, the ALJ failed to explain why the personal examinations or treatment notes are sufficient to support a conclusion that the lack of oxygenation *caused* the arterial sclerotic heart disease that killed Groves. Certainly, the ALJ is entitled to give extra weight to a treating physician's assessment of a patient's condition. But I can see no reason why a treating physician's opinion that one condition caused or contributed to another should be accepted in the face of expert opinions to the contrary, at least where there is no logical explanation for doing so offered by the ALJ. Here, Drs. Fino and Branscomb both rejected Dr. Blue's theory with regard to causation. Although Dr. Branscomb did not believe that Groves suffered from pneumoconiosis, he stated that even if he assumed he did, there would be no reasonable basis to conclude that it contributed to, aggravated, or accelerated Groves' death. Dr. Fino also noted that Dr. Blue's causation theory was not supported by any valid, objective evidence. Dr. Fino's opinion then cited to several studies concluding that pneumoconiosis did not increase the likelihood of coronary artery disease.[1] Simply dismissing

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[1] Among the works cited by Dr. Fino were the article "Mortality From Heart Disease in Coal Miners," published by Dr. Coestello, et al., in the journal *Chest*, an article by Dr. Lindars in 108 *Journal of Pathology* 249-59, a textbook entitled *Occupational Lung Disorders*

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the opinions of Drs. Fino and Branscomb, as the ALJ did, because they did not personally examine the patient or because they did not believe that Groves suffered from pneumoconiosis misses the point. The personal examination and treatment of Groves over the course of his lifetime does not obviously place Dr. Blue in a better position to determine whether one condition could have caused the other. If there were a reason to believe that personal examination would enable a treating doctor to better assess the possibility that two conditions were causally connected, then reliance on Dr. Blue's conclusion would be reasonable. But the ALJ gave no such reason. *See Peabody Coal Co. v. McCandless*, 255 F.3d 465, 468 (7th Cir. 2001). Further, Dr. Blue's opinion and treatment notes contain no objective support for his lack of oxygenation theory. Drs. Fino and Branscomb both discredit Dr. Blue's theory as unsupported, and the only objective medical support cited in the record undermines Dr. Blue's theory.[2] The ALJ failed to critically analyze Dr. Blue's causation theory or discount the opinions of Drs. Fino or Branscomb on any logical grounds. Hence, I would remand for further proceedings consistent with my dissent.

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published by Dr. W. Raymond Parkes, the *Textbook of Occupational Lung Diseases* published by Morgan and Seaton, and a textbook entitled *Occupational Respiratory Disorders*, published by the U.S. Department of Health and Human Services.

[2] The ALJ also failed to address the qualifications of the doctors. Dr. Fino is a board-certified specialist in internal medicine and pulmonary disease. Dr. Branscomb is a Professor of Medicine at the University of Alabama at Birmingham, and has expertise in the diagnosis and treatment of pulmonary disease. Dr. Blue, however, has only a general practitioner's experience with pulmonary diseases.

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

00-3867

PEABODY COAL CO.,
Petitioner,

v.

WILMA J. GROVES; DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR,
Respondents.

Before: KENNEDY, MOORE, and COLE, Circuit Judges.

JUDGMENT

THIS MATTER came before the court upon the petition of Peabody Coal Co. to review an order of the Benefits Review board.

UPON FULL REVIEW of the record and the briefs and arguments of counsel, we conclude that the decision of the agency should be affirmed, and accordingly:

IT IS ORDERED that the benefits award by the Benefits Review Board in this matter is AFFIRMED.

ENTERED BY ORDER OF THE COURT

/s/ Leonard Green, Clerk

U.S. Department of Labor Benefits Review Board
P. O. Box 37601
Washington, DC 20013-7601
(SEAL)

BRB No. 99-0341 BLA

WILMA J. GROVES (Widow of ELZE GROVES)	DATE ISSUED: *May 17, 2000*
Claiment-Respondent	
v.	
PEABODY COAL COMPANY	ORDER ON MOTION FOR RECONSIDERATION
Employer-Petitioner	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR	
Party-in-Interest	

As no member of the panel has affirmatively voted to vacate or modify the decision herein, the motion for reconsideration filed by employer is DENIED. 33 U.S.C. §921(b)(5); 20 C.F.R. §§801.301(b), 802.407(a), 802.409.[1]

[1] Further review of the disposition of the instant case may be obtained by appeal to the United States Court of Appeals of the appropriate circuit.

By Order of the Board:

s/ _____
Thomas O. Shepherd, Jr.
Clerk of the Board

U.S. Department of Labor Benefits Review Board
P. O. Box 37601
Washington, DC 20013-7601
(SEAL)

BRB No. 99-034 1 BLA

WILMA J. GROVES (Widow of ELZE GROVES)	NOT PUBLISHED
Claiment-Respondent	DATE ISSUED: DEC. 22, 1999
v.	
PEABODY COAL COMPANY	DECISION and ORDER
Employer-Petitioner	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR	
Party-in-Interest	

Appeal of the Decision and Order On Remand Awarding Benefits of Thomas F. Phalen, Jr., Administrative Law Judge, United States Department of Labor.

Joseph Kelley (Monhollon & Kelley, P.S.C.), Madisonville, Kentucky, for claimant.

Richard Davis (Arter & Hadden, LLP), Washington, D.C., for employer.

Before: HALL, Chief Administrative Appeals Judge, SMITH, Administrative Appeals Judge, and NELSON, Acting Administrative Appeals Judge.

PER CURIAM:

Employer appeals the Decision and Order On Remand Awarding Benefits (96-BLA-1586) of Administrative Law Judge Thomas F. Phalen, Jr. on a claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §901 *et seq.* (the Act).[1] The administrative law judge found, based

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[1] Claimant, Wilma J. Groves, is the widow of the miner, Elze Groves, who died on April 30, 1995. The death certificate lists the causes of death as cardiac arrest due to acute "MCI" due to "ASHD". Director's Exhibit 12. The miner initially filed a claim on November 7, 1988, which was finally denied by the district director on May 2, 1989, Director's Exhibit 40. Claimant filed the instant claim on May 11, 1995. After denial by the district director, Director's Exhibit 20, the administrative law judge held a hearing and issued a Decision and Order denying benefits on June 30, 1997. The administrative law judge concluded that claimant established the existence of pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4), but found the evidence insufficient to establish that the miner's death was due to the disease pursuant to 20 C.F.R. §718.205(c), and accordingly, denied benefits. Subsequent to an appeal by claimant, the Board vacated the denial of benefits. *Groves v. Peabody Coal Co.*, .BRB No. 97-1469 BLA (Jul. 14, 1998) (unpub.). While the Board rejected claimant's challenge to the administrative law judge's finding of no pneumoconiosis at Section 718.202(a)(1), it affirmed the finding of the presence of the disease pursuant to Section 718.202(a)(4). *Id.* The Board, however, vacated the administrative law judge's determination that claimant failed to establish death due to pneumoconiosis pursuant to Section 718.205(c)(2) as the administrative law [judge] failed to consider treatment notes by Dr. Blue which might have provided adequate documentation for his conclusion that the miner's death was due to pneumoconiosis. *Id.* The Board also held that, since the administrative law judge permissibly accorded greater weight to Dr. Blue, as claimant's treating physician at Section 718.202(a)(4), his failure to do so at Section 718.205(c)(2) was inconsistent. Finally, the Board held that, in weighing the evidence, the administrative law judge failed to consider whether the opinions of Drs. Fino and Branscomb were based on an erroneous underlying premise, i.e., that the miner did not suffer from pneumoconiosis. Accordingly, the Board remanded the case for consideration of these issues. On November 24, 1998, the administrative law

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primarily on the opinions of the miner's treating physicians, that claimant established that the miner's death was due to pneumoconiosis pursuant to 20 C.F.R. §718.205(c). Decision and Order on Remand at 3-7. Accordingly, survivor's benefits were awarded.

On appeal, employer contends that the administrative law judge erroneously relied on the opinions of Dr. Blue, the miner's treating physician, over the contrary opinions of Drs. Fino and Branscomb, and that the administrative law judge therefore erred in finding that the miner's death was due to pneumoconiosis pursuant to Section 718.205(c). Employer further contends that the administrative law judge's finding that the miner established the existence of pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4) was erroneous. Claimant responds and urges affirmance of the award of benefits. The Director, Office of Workers' Compensation Programs (the Director), as party-in-interest has declined to file a brief.

The Board's scope of review is defined by statute. If the administrative law judge's findings of fact and conclusions of law are supported by substantial evidence, are rational, and are consistent with applicable law, they are binding upon this Board and may not be disturbed. 33 U.S.C. §921(b)(3), as incorporated into the Act by 30 U.S.C. §932(a); O'*Keeffe v. Smith, Hinchman & Grylls Associates, Inc.*, 380 U.S. 359 (1965).

In order to establish entitlement on a survivor's claim pursuant to Section 718.205(c), a claimant must establish

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judge issued the Decision and Order On Remand Awarding Benefits from which employer now appeals.

that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death. *See Brown v. Rock Creek Mining Co., Inc.,* 996 F.2d 812, 17 BLR 2-135 (6th Cir. 1993); *see also Northern Coal Co. v. Director, OWCP [Pickup],* 100 F.3d 871,20 BLR 2-335 (10th Cir. 1996); *Shuff v. Cedar Coal Co.,* 967 F.2d 977, 16 BLR 2-90 (4th Cir. 1992), *cert. denied,* 113 S.Ct. 969 (1993); *Lukosevicz v. Director, OWCP,* 888 F.2d 1001, 13 BLR 2-100 (3d Cir. 1989). A claimant may establish that pneumoconiosis was a substantially contributing cause of the miner's death by demonstrating that the disease hastened the miner's death. *See Brown, supra.*

Employer contends that the administrative law judge erred in finding that the evidence of record supported a finding that the miner's death was due to pneumoconiosis pursuant to Section 718.205(c) as he improperly discredited the medical opinions of both Drs. Branscomb, Employer's Exhibit 1, and Fino, Employer's Exhibit 2, because these physicians failed to diagnose the existence of pneumoconiosis. Employer asserts that, although Dr. Branscomb concluded that the miner did not suffer from pneumoconiosis, he nevertheless specifically found that, even if the miner suffered from the disease, it did not contribute to his death. Employer also asserts that Dr. Fino's conclusion was not based on his belief that the miner did not have pneumoconiosis, but was instead based on his views regarding the relationship between the miner's heart disease and his pneumoconiosis. Employer further contends that the administrative law erred in discrediting the opinions of Drs. Fino and Branscomb merely because they had not examined the miner, and that the administrative law judge erred in failing to take into account the physicians' relative qualifications. Finally,

regarding the administrative law judge's finding at Section 718.205(c), employer contends that the administrative law judge erred in finding Dr. Blue's opinions supportive of a finding of death due to pneumoconiosis as the administrative law judge erroneously relied on Dr. Blue's treatment notes which made no mention of the cause of death and presented no objective evidence of the miner's conditions.

We reject employer's assertions and affirm the administrative law judge's finding that claimant has established that the miner's death was due to pneumoconiosis pursuant to Section 718.205(c). *See Brown, supra.* Contrary to employer's assertion, the administrative law judge permissibly accorded greatest weight to the miner's treating physician, Dr. Blue, as the administrative law judge found that Dr. Blue had treated the miner for a lengthy period of time. Further, the administrative law judge rationally concluded that Dr. Blue's conclusion, that the miner's lung disease which was secondary to pneumoconiosis, led to a decreased oxygenation to the miner's tissues which, in turn, hastened the miner's death, Director's Exhibits 36, 37, supported a finding that pneumoconiosis caused the miner's death pursuant to Section 718.205(c). *See Brown, supra.* Accordingly, the administrative law judge provided a rational basis for according greater weight to Dr. Blue, the miner's treating physician. *See Griffith v. Director, OWCP,* 49 F.3d 184, 19 BLR 2-111 (6th Cir. 1995); *Tussey v. Island Creek Coal Co.,* 982 F.2d 1036, 17 BLR 2-16 (6th Cir. 1993). Moreover, contrary to employer's assertion, the administrative law judge, in a permissible exercise of his discretion, accorded less weight to the opinions of Drs. Fino and Branscomb, as these physicians never examined or treated the miner and were thus not as familiar with the miner's condition as Dr. Blue. *See Cole v. East Kentucky*

Collieries, 20 BLR 1-51 (1996); *see also Griffith, supra; Onderko v. Director,* OWCP, 14 BLR 1-2 (1989); *Revnack v. Director, OWCP,* 7 BLR 1-771 (1985). Moreover, the administrative law judge permissibly concluded that the opinion of Dr. Fino was entitled to less weight as Dr. Fino ruled out the existence of pneumoconiosis in the miner, when in fact the presence of the disease had been established.[2] *See Trujillo v. Kaiser Steel Corp.,* 8 BLR 1-472 (1986); *see also Clark v. Karst-Robbins Coal Co.,* 12 BLR 1-149 (1989)(en *banc); Peskie v. United States Steel Corp.,* 8 BLR 1-126 *(1985); Lucostic v. United States Steel Corp.* 8 BLR 1-46 (1985).

Finally, employer asserts that the administrative law judge's previous finding that claimant established the existence of pneumoconiosis at Section 718.202(a)(4), which was affirmed by the Board, *see Groves,* slip op. at 3, is erroneous. Inasmuch as the Board's holding affirming the administrative law judge's finding of the existence of pneumoconiosis was not challenged by employer through either a motion for reconsideration or appeal to the United States Court of Appeals, we hold that the Board's previous holding on the matter constitutes the law of the case, *see Williams v. Healy-Ball-Grienfield,* 22 BRBS 234 (1989); *Bridges v. Director,* 6 BLR 1-988 (1984) and we hold that

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[2] Employer correctly notes that Dr. Branscomb concluded that, while the miner did not suffer from pneumoconiosis, even if he had the disease it would not have hastened his death. Employer's Exhibit 1. Nevertheless, as discussed, *supra,* the administrative law judge. has provided an affirmable basis for crediting the opinion of Dr. Blue over that of Dr. Branscomb. *See Kozele v. Rochester & Pittsburgh Coal Co.,* 6 BLR 1-378 (1983).

employer is precluded from raising the issue before the Board at this time.

Accordingly the administrative law judge's Decision and Order On Remand Awarding Benefits is affirmed.

SO ORDERED.

s/ _____
BETTY JEAN HALL, Chief
Administrative Appeals Judge

s/ _____
ROY P. SMITH
Administrative Appeals Judge

s/ _____
MALCOLM D.NELSON, Acting
Administrative Appeals Judge

U.S. Department of Labor
Office of Administrative Law Judges
525 Vine Street, Suite 900
Cincinnati, Ohio 45202
(513) 684-3252 Telephone
(513) 684-6108 Facsimile

(SEAL)

Date: November 24, 1998

Case No.: 1996-BLA-1586

In the Matter of
WILMA J. GROVES, Widow of
ELZE GROVES,
Claimant,

v.

PEABODY COAL COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

BEFORE: Hon. Thomas F. Phalen, Jr.
Administrative Law Judge

DECISION AND ORDER ON REMAND AWARDING BENEFITS

This proceeding arises from a claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1972, and the Black Lung Benefits Reform Act of 1977, 30 U.S.C. §§ 901-962 (hereinafter referred to as "the Act"). This case was referred to the Office of

Administrative Law Judges by the District Director, Office of Workers' Compensation Programs.[2] Benefits are provided under the Act to a miner who is totally disabled due to pneumoconiosis and to certain survivors of a miner who died due to or while totally disabled (or in certain cases, partially) disabled by pneumoconiosis. Pneumoconiosis means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

On June 30, 1997, I issued a Decision and Order denying Widow black lung benefits. In that decision, I determined that Miner suffered from pneumoconiosis based on the medical opinion evidence. (Decision and Order at 12) I then found that the evidence was not sufficient to establish that Miner's death was due to pneumoconiosis. (Decision and Order at 12) Widow appealed my Decision and Order to the Benefits Review Board on July 21, 1997. The Board issued a Decision and Order on July 14, 1998, affirming in part, vacating in part, and remanding the case to the Office of Administrative Law Judges for further consideration of the medical evidence. Specifically, the Board affirmed my finding that the medical opinion evidence establishes the existence of pneumoconiosis pursuant to § 718.202(a)(4). The Board vacated my finding that the medical evidence was insufficient to establish that Miner's death was due to pneumoconiosis. The Board determined that I failed to make specific findings of fact regarding Dr. Blue's treatment notes and failed to properly weigh the opinions of Drs.

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[2] Formerly titled Deputy Commissioner. *See* Federal Register, Vol. 55, No. 134, Thursday, July 12, 1990.

Branscomb and Fino. Therefore, I am instructed on remand to reconsider the credibility of Drs. Blue, Branscomb, and Fino.[3]

The findings of fact contained in the June 30, 1997, Decision and Order are adopted herein except to the extent that they are inconsistent with this decision or to the extent that they were vacated by the Board. The conclusions of law which follow are based upon an analysis of the record, including all documentary evidence provided, statutory provisions, regulations, case law, and the arguments of the parties.

Pneumoconiosis:

In my prior Decision and Order, I found by a preponderance of the medical opinion evidence that Miner suffered from pneumoconiosis. As the Board has upheld this finding under § 718.202(a)(4), I will reiterate that Widow has established by a preponderance of the medical opinion evidence that pneumoconiosis existed in her husband's lungs.

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[3] Upon motion by the Employer dated October 15, 1998, an Order dated October 26, 1998 was issued by the undersigned giving the parties until November 6, 1998 to file briefs in support of their respective positions in the above matter. On November 12, 1998, a remand brief was received from the Claimant dated November 6, 1998. On November 16, 1998, a remand brief was received from the Employer dated November 11, 1998. Neither party filed or postmarked a brief on or before November 6, 1998, thus rendering those briefs "late filed." Therefore, the briefs are rejected.

Arising out of Coal Mine Employment:

In order to be eligible for benefits under the Act, Widow must prove that Miner's pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* The parties originally stipulated that Miner worked at least twenty-four years in the coal mines. I have reviewed the record and find the same. Therefore, as no rebuttal evidence was presented, I find that Miner's pneumoconiosis arose out of his coal mine employment in accordance with the rebuttable presumption set forth in § 718.203(a).

Death Due to Pneumoconiosis:

In order to be eligible for benefits, Widow must also prove that Miner's death was caused by pneumoconiosis. § 718.205(c). Although the Board requires that death must be "significantly" related to or aggravated by pneumoconiosis, the circuit courts have developed the "hastening death" standard which requires establishment of a lesser causal nexus between pneumoconiosis and the miner's death. The Sixth Circuit[4] reaffirmed its holding in *Brown v. Rock Creek Mining Corp.*, 996 F.2d 812 (6th Cir. 1993) (J. Batchelder dissenting), to state that benefits are

[4] The Benefits Review Board has held that the law of the circuit in which the Miner's last coal mine employment occurred is controlling. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989). The Miner's last coal mine employment took place in Kentucky, which falls under the Sixth Circuit's jurisdiction.

awarded to a survivor who establishes that "pneumoconiosis is a substantially contributing cause or factor leading to the miner's death if it serves to hasten that death in any way." *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995). In order to recover benefits, Widow must prove that pneumoconiosis hastened her husband's death in some manner.

The following medical records are pertinent to the causation analysis: hospital records from April 30, 1995 (Dir. Ex. 36); death certificate dated April 30, 1995 (Dir. Ex. 12); Dr. Blue's letter dated February 2, 1996 (Dir. Ex. 37); Dr. Blue's and Dr. Johnson's treatment notes 1973 to April 30, 1995, (Dir. Ex. 36); Dr. Younes' medical report dated March 14, 1996 (Dir. Ex. 38); Dr. Branscomb's medical report dated August 23, 1996 (Er. Ex. 1); and Dr. Fino's medical report dated September 4, 1996 (Er. Ex. 2).

Miner was brought to the emergency room by ambulance on April 30, 1995. (Dir. Ex. 36) He was in full cardiac arrest. (Dir. Ex. 36) Dr. Benedict Principe was Miner's attending physician and could not revive Miner after forty-five minutes. (Dir. Ex. 36) Miner died on April 30, 1995. (Dir. Ex. 12) Dr. Principe completed the death certificate (Dir. Ex. 12) He listed the causes of death as cardiac arrest, acute myocardial infarction, and arteriosclerotic heart disease. (Dir. Ex. 12)

Dr. Blue examined and treated Miner for breathing problems on April 14, 1994, October 11, 1994, April 16, 1993, October 15, 1993, April 17, 1992, March 12, 1992, May 4, 1992, October 19, 1992, and January 3, 1991, March 5, 1991, June 4, 1991, September 6, 1991, December 9, 1991, January 16, 1990, January 18, 1990, March 13, 1990, November 26, 1990, March 28, 1989, April 5,

1989, August 14, 1989, November 14, 1989, February 18, 1988, February 23, 1987, February 27, 1987, March 5, 1987, (Dir. Ex. 36) Throughout Miner's course of treatment, Dr. Blue diagnosed chronic obstructive pulmonary disease, HCVD, diabetes, hyperlipidemia, osteoarthritis, bronchitis, conjunctivitis, sinusitis, hypertension, acute bronchitis, coronary heart disease, cystic lesion, (Dir. Ex. 36) Dr. Blue noted that during a number of examinations Miner had decreased breath sounds, rhonchi, and wheezes.

There is evidence in the record that Dr. Robert Johnson also treated Miner for pulmonary problems. (Dir. Ex. 36) As of September 23, 1987, Dr. Johnson reported that he was Miner's treating physician for fifteen years. (Dir. Ex. 36) He noted that Miner worked in the coal mines for thirty-three years. (Dir. Ex. 36) He recorded that Miner had severe shortness of breath, scattered wet rales, rhonchi, and wheezes throughout both lung fields, prolongation of the expiratory phase at rest, and a cyanotic complexion. (Dir. Ex. 36) He performed a chest x-ray and found evidence of Category II/III pneumoconiosis. (Dir. Ex. 36) He also performed a pulmonary function test. (Dir. Ex. 36) Dr. Johnson opined that Miner had a progressive development of loss of pulmonary function, found that he had advanced, disabling coal workers' pneumoconiosis, and was totally and permanently disabled from performing any coal mine work. (Dir. Ex. 36)

Dr. William Blue submitted the following report on February 2, 1996. (Dir. Ex. 37)

To Whom It May Concern:

Mr. Elze Groves was a patient of mine for a considerable period of time prior to his death. He

basically had to [sic] significant problems, with the third being related to the first two.

The three disease entities which he had were:

1. Lung disease secondary to pneumoconiosis and a lack of oxygenation.

2. Metabolic problems with sugar and fat metabolism.

3. Hypertension.

The most significant problem was the lung disease which was a result of many years in the coal mines, and a decreased oxygenation of his peripheral tissues because of the lung disease. This was no doubt contributory to his diabetes and his metabolic demands were less than adequate because of his lung disease.

The arterial sclerotic [sic] heart disease which eventually and quite rapidly caused his demise was largely due to the product of a decreased oxygenation of his major arteries and the metabolic stresses from his intermediary metabolism which of course was directly related to the lack of oxygenation which was directly related to his lack of oxygenation (*sic*) which was secondary to his pneumoconiosis.

In my opion (*sic*) Mr. Groves was a product of many years in the mines with the primary lack of oxygenation to his tissues speeding his death significantly.

His immediate cause of death was the coronary artery disease which was largely a result of the chronic low oxygen assaturation superimposed on his metabolic abnormalities of sugar and

> lipids. It is my opion (*sic*) that his pneumoconiosis was probably a third to a half responsible for his final demise.
>
> I knew Else (*sic*) well and took care of him for years. He did not like to coplain (*sic*) and he did try to take care of himself after he was retired from the mines. He did quite well at doing this all things considered.
>
> Coal workers pneumoconiosis did undoubtedly contribute significantly to his death.
>
> W.B. Blue, M.D.

(Dir. Ex. 37)

Dr. Maan Younes issued a consultative report on March 14, 1996. (Dir. Ex. 38) He opined that Miner did not suffer from pneumoconiosis. (Dir. Ex. 38) He also opined that pneumoconiosis was neither a substantially contributing factor nor a contributing fact to Miner's death. (Dir. Ex. 38) In his explanation, Dr. Younes stated, "The circumstances of Mr. Grove's death were not elaborated upon adequately from the records that you sent me." (Dir. Ex. 38) His opinion relies on Dr. Blue's finding of coronary artery disease as Miner's immediate cause of death, one pulmonary function test and arterial blood gas study from March 1990, and one chest x-ray study from March 25, 1990. (Dir. Ex. 38) He opined that Miner had chronic bronchitis, most likely secondary to his history of heavy smoking and also from coal dust exposure. Dr. Younes further stated, "Although, the documentation is not complete in terms of his respiratory status in 1995, the year he died; however, review of the progress notes of his routine visits to his Family Physician showed that his

major problems were related to his Coronary Artery Disease and to his Diabetes." (Dir. Ex. 38)

On August 23, 1996, Dr. Ben Branscomb issued a consultative report. (Er. Ex. 1) He reviewed and summarized Miner's medical records. (Er. Ex. 1) Dr. Branscomb opined that Miner had no occupational pulmonary disease and no coal workers' pneumoconiosis. (Er. Ex. 1) He concluded that Miner was an overweight and hypertensive diabetic with severe coronary artery disease which led to many cardiac problems. (Er. Ex. 1) His review of the records showed that Miner was treated for obesity, smoking cessation, orthopedic problems, and pulmonary embolism. (Er. Ex. 1) He determined that Miner probably had mild chronic obstructive pulmonary disease which did not cause any pulmonary impairment. (Er. Ex. 1) Dr. Branscomb concluded that Miner's death was caused by cardiac disease and not caused by, aggravated by, or contributed to by any pulmonary disease or coal mine dust exposure. (Er. Ex. 1) Even after assuming that Miner suffered from pneumoconiosis, Dr. Branscomb opined that there would still be no reasonable basis for attributing any aggravation, contribution to, or acceleration of his death to pneumoconiosis. (Er. Ex. 1)

Dr. Gregory Fino reviewed and summarized Miner's medical records and issued a consultative report on September 11, 1996. (Er. Ex. 2) Dr. Fino opined that Miner did not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure. (Er. Ex. 2) He found the majority of the chest x-rays were negative for pneumoconiosis. (Er. Ex. 2) He determined that the spirometries and arterial blood gas studies were normal; thus, Miner retained the physiologic capacity to perform his usual coal mine employment. (Er. Ex. 2) Dr. Fino

concluded that Miner's death was not hastened by pneumoconiosis. (Er. Ex. 2) He found that Miner's death was sudden and due to atherosclerotic heart disease and acute myocardial infarction. (Er. Ex. 2) He opined that there is no connection between cardiac arrest and coal mine dust exposure. (Er. Ex. 2)

Any finding of death due to pneumoconiosis under § 718.205(c) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

I give less weight to the opinion of Dr. Younes. His consultative report is not well-reasoned. He relied solely on Dr. Blue's written letter from 1996, one pulmonary function test from 1990, one arterial blood gas study from 1990, and one chest x-ray from 1990. He did not review the remaining medical records, the hospital reports from Miner's last trip to the emergency room, or even the death certificate. Furthermore, Dr. Younes even admitted that the circumstances of Miner's death were not elaborated on in the medical records he reviewed and that the documentation of Miner's respiratory status was not complete in 1995 when Miner died.

I give less weight to the opinions of Drs. Branscomb and Fino. Neither physician ever personally examined Miner. *Cole v. East Kentucky Collieries*, 20 B.L.R. 1-51, 1-55 (1996) (It is within the Administrative Law Judge's

discretion to accord less weight to the opinions of non-examining physicians); *see also Tackett v. Cargo Mining Co.*, 12 B.L.R. 1-11 (1988). Since the physicians failed to find any evidence of pneumoconiosis, I find their opinions regarding whether pneumoconiosis hastened Miner's death less credible. *See Bobick v. Saginaw Mining Co.*, 13 B.L.R. 1-52 (1988); *Turgillo* [sic] *v. Kaiser Steel Corp.*, 8 B.L.R. 1-472 (1986); *Hutchens v. Director, OWCP*, 8 B.L.R. 1-16 (1985). As a result, their opinions are entitled to less weight.

I give the most weight to Miner's treating, family physicians, Drs. Johnson and Blue. Their progress reports establish that they treated Miner for nearly twenty-five years. Miner had problems with his breathing during this time and was diagnosis [sic] with, among other things, chronic obstructive pulmonary disease, bronchitis, acute bronchitis, and coal workers' pneumoconiosis. These treatment notes, which show that Miner's lung function was impaired, support Dr. Blue's letter of February 2, 1996, and bolster his credibility. Dr. Blue found that Miner's lung disease secondary to pneumoconiosis and lack of oxygenation contributed to speeding up Miner's demise. Pneumoconiosis compromised Miner's lung function and was responsible for hastening Miner's death. Therefore, I find Dr. Blue's letter and treatment notes are persuasive in establishing that Miner's death was hastened by pneumoconiosis.

Although I have considered the death certificate and hospital reports from Dr. Benedict, I give them less weight because the Sixth Circuit does not require that the immediate cause of death be pneumoconiosis. Benefits are awarded to a survivor who establishes that "pneumoconiosis is a substantially contributing cause or factor leading

to the miner's death if it serves to hasten that death in ***any way***." *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (emphasis added). Therefore, it is possible for Miner's immediate cause of death to have been cardiac arrest and for his death to still be due to pneumoconiosis because it compromised his lung function and thereby hastened his death.

In summary, I find Dr. Blue's opinion and treatment notes to be the most credible evidence in the record regarding the cause of Miner's death. Dr. Younes submitted an unreasoned opinion, while Drs. Branscomb and Fino submitted opinions that were less credible because they did not make a finding of pneumoconiosis. As a result, I find that Widow has established by a preponderance of the evidence that her husband's death was due to pneumoconiosis.

Entitlement:

As Widow has established that Miner suffered from pneumoconiosis, that pneumoconiosis arose out of his coal mine employment, and that pneumoconiosis was a substantial contributing factor to his death, I find that she is entitled to benefits under the Act and applicable regulations.

Attorney's Fees:

No award of attorney's fees for services to Widow is made herein, since no application has been received from counsel. A period of 30 days is hereby allowed for Widow's counsel to submit an application, with a service sheet showing that service has been made upon all parties, including Widow. The parties have 10 days following

receipt of any such application within which to file their objections. The Act prohibits the charging of any fee in the absence of such approval. *See,* §§ 725.365 and 725.366.

ORDER

It is therefore ORDERED that the claim of Wilma Groves for benefits under the Act is GRANTED. Peabody Coal Company is hereby ORDERED to pay benefits to Wilma J. Groves beginning with the date of filing on May 11, 1995.

s/ _____
THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.**

U.S. Department of Labor Benefits Review Board
P.O. Box 37601
Washington, DC
20013-7601

(SEAL)

BRB No. 97-1469 BLA

WILMA J GROVES (Widow of ELZE GROVES) Claimant-Petitioner	
V.	
PEABODY COAL COMPANY Employer-Respondent	DATE ISSUED: JULY 14 1998
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR Party-in-Interest	DECISION and ORDER

Appeal of the Decision and Order of Thomas F. Phalen, Jr., Administrative Law Judge, United States Department of Labor.

Joseph H. Kelley (Monhollon & Kelley, P.S.C.), Madisonville, Kentucky, for claimant.

Mark E. Solomons (Arter & Hadden), Washington, D.C., for employer.

Before: HALL, Chief Administrative Appeals Judge, SMITH and MCGRANERY, Administrative Appeals Judges.

PER CURIAM:

Claimant, widow of the deceased miner, appeals the Decision and Order (96-BLA-1586) of Administrative Law Judge Thomas F. Phalen, Jr., denying benefits on a survivor's claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §901 èt *seq.* (the Act). Based on the date of filing, the administrative law judge adjudicated the claim pursuant to 20 C. F .R. Part 718.[1] The administrative law judge concluded that the evidence of record was sufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4), but insufficient to establish death due to pneumoconiosis pursuant to 20 C.F.R. §718.205(c). Accordingly, benefits were denied. On appeal, claimant contends that the evidence is sufficient to establish that the miner's death was due to pneumoconiosis. Employer responds, urging affirmance of the denial. The Director, Office of Workers' Compensation Programs (the Director), has filed a letter indicating that he would not participate in this appeal.

The Board's scope of review is defined by statute. The administrative law judge's Decision and Order must be affirmed if it is supported by substantial evidence, is rational, and is in accordance with applicable law. 33 U.S.C. §921(b)(3), as incorporated by 30 U.S.C. §932(a); *O'Keeffe v. Smith, Hinchman & Grylls Associates, Inc.*, 380 U.S. 359 (1965).

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[1] The miner filed a claim for benefits on November 7, 1988, which was denied by the district director on May 2, 1989. Director's Exhibit 40. No further action was taken and the miner's claim was considered abandoned. The miner died on April 30, 1995. Director's Exhibit 12. Claimant filed her survivor's claim for benefits on May 11, 1995. Director's Exhibit 1. Only the survivor's claim is at issue.

In order to establish entitlement to benefits pursuant to 20 C.F.R. Part 718 on a survivor's claim filed after January 1, 1982, claimant must establish that the miner suffered from pneumoconiosis; that the pneumoconiosis arose out of coal mine employment; and that the miner's death was due to, or substantially contributed to, pneumoconiosis. *See* 20 C.F.R. §718.1, 718.205, 725.201; *Brown v. Rock Creek Mining Co., Inc.* 996 F.2d 812, 17 BLR 2-135 (6th Cir. 1993); *Trumbo v. Reading Anthracite Co.,* 17 BLR 1-85(1993); *Haduck v. Director, OWCP,* 14 BLR 1-29(1990); *Boyd v. Director, OWCP,* 11 BLR 1-39 (1988).

Claimant initially contends that the administrative law judge erred in failing to find the x-ray evidence of record insufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(1). We disagree. The administrative law judge considered the x-ray evidence of record pursuant to Section 718.202(a)(1) and permissibly accorded greater weight to the x-ray interpretations of the readers with superior qualifications and to the preponderance of negative x-ray readings. *Woodward v. Director, OWCP,* 991 F.2d 314, 17 BLR 2-77 (6th Cir. 1993); *Worhach v. Director, OWCP,* 17 BLR 1-105 (1993); *Edmiston v. F & R Coal Co.,* 14 BLR 1-65 (1990); *Clark v. Karst-Robbins Coal Co.,* 12 BLR 1-149 (1989); *Trent* v. *Director, OWCP,* 11 BLR 1-26 (1987). *Roberts v. Bethlehem Mines Corp.,* 8 BLR 1-2 11 (1985); Decision and Order at 4-6. We, therefore, affirm the administrative law judge's finding that the x-ray evidence was insufficient to establish the existence of pneumoconiosis pursuant to Section 718.202(a)(1).

We note that employer takes issue with the administrative law judge's findings pursuant to Section 718.202(a)(4). *See* Employer's Brief at 18, n. 2. The

administrative law judge, in the instant case, considered the entirety of the medical opinion evidence at subsection (a)(4) and accorded greatest weight to the opinions of Drs. Johnson and Blue, as buttressed by the opinions of Drs. Penman, Meyers, Younes and Simpao, finding pneumoconiosis, as they were the miner's treating physicians and accorded less weight to the contrary opinions of Drs. Branscomb and Fino as they were non-examining physicians. Decision and Order at 12; Director's Exhibits *15,* 35-38, 40; Employer's Exhibits 1, 2. Contrary to employer's assertion, the reliability of the medical opinions diagnosing pneumoconiosis is not called into question by the weight of the x-ray evidence as the physicians' x-rays diagnosing pneumoconiosis in this case have not been challenged. *See Taylor v. Director, OWCP,* 12 BLR 1-83 (1988); *Fitch v. Director, OWCP,* 9 BLR 1-45 (1986); *Arnoni v. Director, OWCP,* 6 BLR 1-427 (1983); *Director, OWCP v. Rowe,* 710 F.2d 251, *5* BLR 2-97 (6th Cir. 1983). Moreover, an administrative law judge may accord greater weight to a treating physician's opinion even if the record contains opinions by physicians with superior qualifications. *Griffith* [Myrtle] *v. Director, OWCP,* 49 F.3d 184, 19 BLR 2-111 (6th Cir. 1995); *Onderko v. Director, OWCP,* 14 BLR 1-2 (1989); *Clark, supra; Defore v. Alabama By-Products Corp.,* 12 BLR 1-27 (1988); *Worley v. Blue Diamond Coal Co.,* 12 BLR 1-20 (1988); *Revnack v. Director, OWCP,* 7 BLR 1-771 (1985); *Price v. Peabody Coal Co.,* 7 BLR 1-671 *(1985); Wilson v. United States Steel Corp.,* 6 BLR 1-1055 (1984). We therefore affirm the administrative law judge's findings pursuant to Section 718.202(a)(4) as supported by substantial evidence.

Claimant further contends that the administrative law judge erred at Section 718.205(c)(2) in according

greater weight to the opinions of Drs. Branscomb and Fino, finding death due to cardiac disease, than to Dr. Blue's finding that pneumoconiosis hastened death.[2] The administrative law judge accorded less weight to Dr. Blue's opinion as not well documented, as the physician failed to explain his findings, and as it was the only opinion of record finding that the miner's death was hastened by pneumoconiosis. Director's Exhibit 36; Decision and Order at 12. Although the administrative law judge stated that Dr. Blue's opinion was undocumented, the record indicates that there are treatment notes by Dr. Blue that, when considered with his opinion, may provide adequate documentation. Director's Exhibits 34, 36; *Hanley v. Director, OWCP*, 8 BLR 1-323 *(1985)*. The administrative law judge mentioned these treatment notes but did not specifically address them in making his credibility determination. As the administrative law judge failed to provide the reasons and bases for his findings on this issue as required by the Administrative Procedure Act (APA), 5 U.S.C. §557(c)(3)(A), as incorporated into the Act by 5 U.S.C. §554(c)(2), 33 U.S.C. §919(d) and 30 U.S.C. §932(a), we agree with claimant that this case must be remanded to the administrative law judge to make specific findings of fact. *Wojtowicz v. Duquesne Light Co.*, 12 BLR 1-162 (1989). Additionally, in his discussion of the evidence pursuant to

[2] The administrative law judge found that claimant could not establish death due to pneumoconiosis pursuant to 20 C.F.R. §718.205(c)(1) and (3) as the evidence of record establishes that the immediate cause of death was cardiac arrest and as there is no evidence of complicated pneumoconiosis in the record. Decision and Order at 4. As these findings are not challenged on appeal, they are affirmed. *Skrack v. Island Creek Coal Co.*, 6 BLR 1-710 (1983).

Section 718.202(a)(4), the administrative law judge accorded greater weight to Dr. Blue as claimant's treating physician and less weight to Drs. Branscomb and Fino as non-examining physicians. Director's Exhibit 36; Employer's Exhibits 1, 2; Decision and Order at 12. Thus, as claimant contends, the administrative law judge's treatment of the evidence pursuant to Section 718.205(c) appears to be inconsistent with the conclusions reached pursuant to Section 718.202(a)(4). Moreover, the administrative law judge failed to discuss whether the opinions of Drs. Branscomb and Fino were based on an incorrect underlying premise, that the miner did not have pneumoconiosis, which may affect the credibility of the opinions at Section 718.205(c)(2) in determining if the miner's death was due to pneumoconiosis. *See Bobick v. Saginaw Mining Co.*, 13 BLR 1-52 (1988); *Trugillo* [sic] *v. Kaiser Steel Corp.*, 8 BLR 1-472 (1986); *Hutchens v. Director, OWCP*, 8 BLR 1-16 (1985). As this case arises within the jurisdiction of the United States Court of Appeals for the Sixth Circuit, the proper recourse is to remand the case to the administrative law judge for further findings with respect to the medical opinion evidence. *Peabody Coal Co. v. Greer*, 62 F.3d 801, 19 BLR 2-235 (6th Cir. 1995); *Harlan Bell Coal Co. v. Lemar*, 904 F.2d 1042, 14 BLR 2-1 (6th Cir. 1990). We therefore vacate the administrative law judge's finding that the evidence is insufficient to establish death due to pneumoconiosis pursuant to 20 C.F.R. §718.205(c)(2) and remand the case for the administrative law judge to specifically discuss the relevant medical opinion evidence.[3]

[3] Claimant also asserts that "had Dr. Blue been available at the hospital on April 30, 1995, the death certificate would have read differently." Claimant's Brief at 11. This contention is mere speculation

(Continued on following page)

Lafferty v. Cannelton Industries, Inc. 12 BLR 1-190 (1989); *Tackett v. Director, OWCP,* 7 BLR 1-703 *(1985).*

Accordingly, the administrative law judge's Decision and Order denying benefits in this survivor's claim is affirmed in part, vacated in part and the case is remanded to the administrative law judge for further consideration consistent with this opinion.

SO ORDERED.

s/_____
BETTY JEAN HALL, Chief
Administrative Appeals Judge

s/_____
ROY P. SMITH
Administrative Appeals Judge

s/_____
REGINA C. McGRANERY
Administrative Appeals Judge

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and is not relevant medical evidence necessary to carry claimant's burden of proof.

U.S. Department of Labor Office of Administrative Law Judges
525 Vine Street, Suite 900
Cincinnati, Ohio 45202
(513) 684-3252 Telephone
(513) 684-6108 Facsimile

(SEAL)

Date: June 30, 1997

Case No. 96-BLA-1586

In the Matter Of:

WILMA J. GROVES, Widow of
ELZE GROVES, Deceased,

Claimant,

V.

PEABODY COAL COMPANY
PEABODY HOLDING CO., INC.,

Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
APPEARANCES:

Party-in-Interest.

Joseph H. Kelley, Esq.
Madisonville, Kentucky

For the Claimant,

Philip J. Reverman, Jr., Esq.
Louisville, Kentucky

For the Employer,

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This case arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977 [hereinafter referred to as "the Act"], 30 U.S.C. § 901 et seq., and the regulations issued thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

On August 5, 1996, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (Dir. Ex. 41)[1] A formal hearing on this matter was conducted on April 29, 1997 in Madisonville, Kentucky by the undersigned. All parties were afforded a full opportunity to present evidence as provided in the Act and the regulations issued thereunder.

ISSUES

1. Whether the Claimant has one dependent;

2. Whether the Miner had pneumoconiosis as defined by the Act;

3. Whether the Miner's pneumoconiosis arose out of his coal mine employment;

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[1] In this Decision and Order, "Dir. Ex." refers to the Director's exhibits, "Er. Ex." refers to the Employer's exhibits, "Cl. Ex." refers to Claimant's exhibits and "Tr." refers to the transcript of the hearing.

4. Whether the Miner's death was due to pneumoconiosis;

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History:

The Miner in this case filed an application for benefits on November 7, 1988. This application was administratively denied on May 2, 1989. No appeal was taken and the claim was considered abandoned.

The Miner's widow filed an application for benefits on May 11, 1995. (Dir. Ex. 1) On October 26, 1995, the District Director denied the Claimant's application for benefits. (Dir. Ex. 20) An informal conference was held on April 16, 1996 and, on May 1, 1996, the District Director issued a Proposed Decision and Order denying benefits. (Dir. Ex. 39) On May 8, 1996, the Claimant made a timely request for a formal hearing and the case was forwarded to this office. (Dir. Ex. 26, 41) The undersigned Administrative Law Judge conducted a formal hearing on April 29, 1997 in Madisonville, Kentucky.

Background:

The Claimant testified that she and the Miner, who died on April 30, 1995, were married in January of 1955. (Tr. 9) The Claimant stated that the Miner worked in coal and rock dust "all the time." (Tr. 13) The Claimant further

stated that the Miner was not active during the last year of his life. (Tr. 19) Specifically, she stated that he "just didn't have the breath." (*Id.*) Finally, the Claimant stated that the Miner smoked approximately ¾ of a pack of cigarettes per day. (Tr. 23)

Dependency:

The Claimant in this case stated that her son, Doyle, is a dependent for the purposes of augmenting benefits. (Dir. Ex. 1; Tr. 9-10) The evidence indicates that Doyle was born in August of 1958 and is 38 years of age. (Dir. Ex. 8; Tr. 9) The Claimant testified that Doyle is a quadriplegic and resides with her. She stated that Doyle was injured in September of 1983, when he was 25 years of age. (Tr. 10) She further stated that Doyle has to be lifted out of bed because he is paralyzed from the neck down. (Tr. 11) The evidence of record indicates that Doyle was married in 1981 and divorced in 1983. (Dir. Exs. 9, 11).

Section 725.221 states that,

> For the purposes of determining whether a child was dependent upon a deceased miner, the provisions of § 725.209 shall be applicable, except that for purposes of determining the eligibility of a child who is under a disability as defined in section 223(d) of the Social Security Act, such disability must have begun before the child attained age 18. . . .

Because Doyle became disabled after he turned 18, he can not be considered a dependent for the purpose of augmenting benefits.

Widow's Claim:

Because the Claimant filed a survivor's claim after January 1, 1982, entitlement to benefits must be established under the regulatory criteria at Part 718. *See Nealy v. Director, OWCP*. 11 BLR 1-85 (1988). Section 718.205 provides that benefits are available to eligible survivors of a miner whose death was due to pneumoconiosis. An eligible survivor will be entitled to benefits if any of the following criteria are met:

1. Where competent medical evidence establishes that the miner's death was due to pneumoconiosis;

2. Where pneumoconiosis was a substantially contributing factor, or cause, leading to the miner's death, or where death was caused by complications of pneumoconiosis; or

3. Where the presumption set forth in § 718.304 (evidence of complicated pneumoconiosis) is applicable.

§ 718.205(c).

Initially, I note that all competent medical evidence has established that the immediate cause of the Miner's death was cardiac arrest thus, subsection (c)(1) does not apply. Also, because the record contains no evidence of complicated pneumoconiosis, subsection (c)(3) is inapplicable.

Subsection (c)(2), however, is applicable to this claim. The United States Court of Appeals for the Sixth Circuit, under whose appellate jurisdiction this case arises, in accord with the Third, Fourth and Seventh Circuits, has held that the widow of a miner whose death was hastened

by pneumoconiosis is entitled to benefits under the Act. *See Brown v. Rock Creek Mining Co.*, 996 F.2d 812 (6th Cir. 1993); *Lukosevic v. Director. OWCP*, 888 F.2d 977 (4th Cir. 1992); *Peabody Coal Co. v. Director. OWCP*. 972 F.2d 178 (7th Cir. 1992). Specifically, the Sixth Circuit stated that pneumoconiosis "will be found to be a 'substantially contributing cause or factor' of a miner's death in a case in which it has actually hastened his death." Brown, *supra,* at 81.

Pneumoconiosis:

To establish death due to pneumoconiosis, the Claimant must prove that the Miner suffered from pneumoconiosis under any of the methods available under § 7 18.202(a). *Trumbo v. Reading Anthracite Co.* 17 BLR 1-85 (1993). Section 718.202(a) sets forth four methods by which a claimant may establish the existence of pneumoconiosis under this part of the regulations. Under 718 .202(a)(1), a chest x-ray conducted and classified in accordance with § 718.102 may form the basis for a finding of the existence of pneumoconiosis. Several x-ray interpretations are included in the record. They are summarized in the following chart.

DOCTOR	DATE OF X-RAY	EXHIBIT #	READING	DR. QUALIFI-CATIONS
Rold	7-18-73	Dir. Ex. 35	0/0	BCR
Morris	9-9-75	Dir. Ex. 35	0/0	BCR
McLaughlin	7-4-78	Dir. Ex. 35	0/0	BCR
McLaughlin	7-6-78	Dir. Ex. 35	0/0	BCR
McCormick	9-20-78	Dir. Ex. 35	changes possibly related pneumoco-niosis	
Myers	1-9-79	Dir. Ex. 35	chronic interstitial changes	BCR
Smock	3-8-79	Dir. Ex. 35	chronic change at bases	BCR
Stokes	9-20-87	Dir. Ex. 40	1/1	
Johnson	9-22-87	Dir. Ex. 40	2/2	
Penman	10-26-87	Dir. Ex. 40	1/1	
Myers	1-5-88	Dir. Ex. 40	1/1	
Simpao	11-29-88	Dir. Ex. 40	1/1	
Hicks	11-29-88	Dir. Ex. 40	1/1	
Sargent	11-29-88	Dir. Ex. 40	0/0	B/BCR
Mercer	3-23-90	Dir. Ex. 15	0/0	
Sargent	3-23-90	Dir. Ex. 16	0/0	B/BCR
Barrett	3-23-90	Dir. Ex. 18	0/0	B/BCR
O'Bryan	3-24-90	Dir. Ex. 15	Category 1	
Sargent	3-25-90	Dir. Ex. 17	0/0	B/BCR
Barrett	3-25-90	Dir. Ex. 19	0/0	B/BCR

In summary, seven interpretations were positive for pneumoconiosis[2] and 11 interpretations were negative. I find that the numerous readings of no pneumoconiosis by several other B-readers and Board certified physicians outweighs the positive x-ray interpretations of record. I emphasize that the burden is on the Claimant to establish, by a preponderance of the evidence, that the Miner suffered from coal workers' pneumoconiosis. Under Part 718, where the x-ray evidence is in conflict, consideration shall be given to the readers radiological qualifications. *Dixon v. North Camp Coal Co.*, 8 BLR 1-344 (1985). *Aimone v. Morrison Knudson Co.*, 8 BLR 1-32 (1985); *Vance v. Eastern Associated Coal Corp.*, 8 BLR 1-68 (1985). Thus, it is within the discretion of the administrative law judge to assign weight to x-ray interpretations based on the readers' qualifications. *Goss v. Eastern Associated Coal Co.*, 7 BLR 1-400 (1984). Accordingly, greater weight may be assigned to an x-ray interpretation of a B-reader. *Aimone v. Morrison Knudson Co., supra.* In the instant case, a greater number of B-readers and Board certified radiologists found the x-ray evidence to be negative.

The record also contains more negative interpretations than positive. It is within the Court's discretion to defer to numerical superiority of the x-ray interpretations. *Edmiston v. F & R Coal*, 14 BLR 1-65 (1990). The United States Court of Appeals for the Sixth Circuit, under whose

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[2] Dr. McCormick merely stated that the x-ray showed "changes possibly related to pneumoconiosis." I find that this is too equivocal to count as a positive interpretation. Similarly, Dr. Myers and Smock noted chronic interstitial changes and chronic changes at base. These interpretations are too vague to count as a positive interpretation.

appellate jurisdiction this case arises,[3] recently confirmed that consideration of the numerical superiority of the x-ray interpretations, when examined in conjunction with the readers' qualifications, is the proper method for weighing x-ray evidence. *Staton v. Norfolk and Western Railway Co.*, 65 F.3d 55 (6th Cir. 1995) (citing *Woodward v. Director. OWCP*, 991 F.2d 314 (6th Cir. 1993). Consequently, I find that the Claimant has failed to establish, by a preponderance of the x-ray evidence, that the Miner suffered from pneumoconiosis under Section 718.202(a)(1).

A biopsy conducted and reported in compliance with Section 718.106 may also be the basis for a finding of the existence of pneumoconiosis. §718.202(a)(2). However, as no biopsy evidence exists in the record, this section is inapplicable in this case.

Section 718.202(a)(3) provides that it shall be presumed that a miner is suffering from pneumoconiosis if the presumptions described in Sections 718.304, 718.305 or 718.306 are applicable. No x-ray evidence of complicated pneumoconiosis is present in the record, thus Section 718.304 does not apply. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, Section 718.306 is not relevant because it is only applicable to claims of deceased miners.

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[3] The Benefits Review Board has held that the law of the circuit in which the Miner's last coal mine employment occurred is controlling. *Shupe v. Director. OWCP*, 12 BLR 1-200 (1989). The Claimant's last coal mine employment took place in Kentucky, which falls under the Sixth Circuit's jurisdiction.

The fourth and final way to establish the existence of pneumoconiosis is set forth in Section 718.202(a)(4). This subsection provides for such a finding where a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis. Any such finding shall be based upon objective medical evidence and shall be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. *Oggero v. Director. OWCP*, 7 BLR 1-860(1985). Several medical reports have been submitted in conjunction with the Claimant's application for benefits.

Dr. Alexander examined the Miner and submitted reports dated July 25, 1973 and August 8, 1973. (Dir. Ex. 36) He noted that the Miner previously smoked two packs of cigarettes per day and was currently smoking ½ a pack per day. He stated that he found no evidence of pneumoconiosis. Dr. Alexander diagnosed asthma, hypertension, obesity and mild diabetes.

Hospital records indicate that the Miner was hospitalized from September 8, 1975 through September 18, 1975. (Dir. Ex. 36) His admitting diagnosis was hypertensive cardiovascular disease with possible coronary heart disease. The Miner's final diagnosis was essential hypertension, chronic anxiety reaction, and possible coronary artery disease, unproven by electrocardiography.

The Miner was also admitted to the hospital on July 5, 1978 for severe shortness of breath. (Dir. Ex. 35) The

Miner was found to be obese and had the "look and reaction of an alcoholic." He was further described as a "4-5 pack smoker" and was still consuming at least a fifth of wine daily according to his wife. His final diagnosis included the following: possible acute pancreatitis with pseudocyst of the pancreaseor [sic] subphrenic abscess, secondary left lower lobe atelectasis and pneumonia. Dr. Shrewesbury further noted chronic obstructive pulmonary disease with acute bronchial pneumonia and pleuritis.

The record contains hospital records indicating that the Miner was admitted into the hospital on July 8, 1978 and released on July 22, 1978. (Dir. Ex. 40, p. 41) At this time, the Miner was diagnosed with pulmonary emboli involving both lungs.[4]

The record includes outpatient notes dated February 14, 1983. (Dir. Ex. 36) On this date, the Miner was noted to have wheezing and scattered rales of several days duration and acute asthmatic bronchitis.

A hospital record from January 26, 1987 is also included in the record. (Dir. Ex. 36) It indicates that the Miner was admitted with "multiple complaints related to newly diagnosed diabetes mellitus, out of control." The final diagnosis indicated the following: Diabetes mellitus, insulin dependent and hypertension.

Dr. Penman examined the Miner and issued a report dated October 26, 1987. (Dir. Ex. 40, p. 36) His examination included a chest x-ray, pulmonary function testing and arterial blood gas studies. He noted that the Miner

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[4] Pulmonary emboli are blood clots to the lung.

had 33 ½ years of coal mine employment. He further noted that the Miner smoked one pack of cigarettes per day for "many years." Dr. Penman concluded that there was an adequate history of exposure to coal mine dust and x-ray change for a diagnosis of coal workers' pneumoconiosis, stage I. He further noted that the Miner's lung function was impaired.

Dr. Myers examined the Miner and issued a report dated January 5, 1988. (Dir. Ex. 40, p. 29-32) His examination included a chest x-ray, an electrocardiogram, pulmonary function studies and arterial blood gas tests. He noted that the Claimant worked in the coal mines for 33 ½ years and smoked one pack of cigarettes per day for 20 years. Dr. Myers diagnosed the following:

1. Coal workers' pneumoconiosis, Category 1/1-p/p, all zones both lungs.

2. Chronic obstructive pulmonary disease.

3. Status post pulmonary emboli, bilateral.

4. History of pneumonia times three with associated pleural thickening, left elevated hemidiaphragm leaf.

5. Arteriosclerotic hypertensive cardiovascular disease, with cardiomegaly, angina with effort, possible old anteroseptal infarction, functional class III.

6. Diabetes mellitus, Insulin dependent.

7. History of gout.

8. The above are associated with mild hypoxemia by arterial blood gases, although I cannot determine which of his multiple conditions is responsible for such.

Dr. Simpao examined the Miner on November 29, 1988. (Dir. Ex. 40, p. 23) His examination included a chest x-ray, pulmonary function testing and arterial blood gas studies. He noted that the Miner had 33 ½ years of coal mine employment. He further noted that the Miner smoked one pack of cigarettes per day for 25 years. Dr. Simpao diagnosed coal workers' pneumoconiosis, Category 1/1, due to his years of coal dust exposure.

Dr. Johnson, the Miner's treating physician for approximately 15 years, stated that the Miner had advanced pulmonary pneumoconiosis due to his exposure to coal dust. (Dir. Ex. 40, p. 33, 37, 47) He noted that the Miner worked in the coal mines for 33 years. Dr. Johnson also included some of his treatment notes from 1987 and 1988. (*Id.* at 43-45) On at least one occasion, Dr. Johnson diagnosed "black lung."

The records indicate that Dr. Johnson examined the Miner on April 4, 1988. (Dir. Ex. 36) He indicated a diagnosis of "steadily advancing black lung." He referred to this as advanced and in "crippling stages."

The record contains several outpatient notes between November 14, 1989 and October 10, 1992. (Dir. Ex. 36) These records deal with orthopedic problems and cardiovascular disease. There is no reference to any occupational disease or other chronic pulmonary disease.

The record contains a report by Dr. Mercer dated March 23, 1990. (Dir. Ex. 15) He noted that the Miner was admitted to the hospital with a diagnosis of unstable angina pectoris. He further noted that the Miner was referred to him with a history of recurrent episodic chest pain. In the "Past Medical History" section of his report, Dr. Mercer listed black lung, as well as hypertension and

insulin dependent diabetes mellitus. Dr. Mercer diagnosed the Miner with the following:

1. Unstable angina pectoris and the same multiple risk factors including cigarette smoking, lung disease that may be restrictive from pneumoconiosis and recurrent pulmonary emboli and obstructive due to emphysematous disease/chronic bronchitis due to cigarette smoking, obesity, insulin dependent diabetes and hypertensive cardiovascular disease.

A hospital record indicates that the Miner was admitted on March 23, 1990 for unstable angina and a cardiac catheterization was carried out. (Dir. Ex. 15) The final diagnosis included the following:

1. Atherosclerotic cardiovascular disease, coronary artery disease, single vessel severe coronary artery disease of the left circumflex/obtuse marginal with class II angina pectoris, high grade ventricular ectopy non-sustained ventricular tachycardia.
2. Insulin dependent diabetes mellitus.
3. Chronic obstructive pulmonary disease.
4. History of cigarette smoking.
5. Hypertensive cardiovascular disease.
6. History of pulmonary embolism.
7. History of back surgery.
8. History of bursitis in the elbows.
9. Unilateral headache.

Another hospital record dated March 23, 1990 through April 2, 1990 notes that the Miner's primary diagnosis was

intermediate coronary synd. (Dir. Ex. 15) The doctor, whose name is illegible, indicated that the Miner's secondary diagnosis was:

1. coal workers' pneumoconiosis
2. chronic airway obstruct
3. diabetes
4. coronary atherosclerosis
5. drug dermatitis
6. hypertensive heart disease
7. tobacco abuse
8. headache

Dr. Mercer, on a discharge summary dated April 29, 1990, diagnosed cardiac disease, diabetes, chronic obstructive pulmonary disease, cigarette smoking, history of embolism and back surgery.

Dr. O'Bryan issued a consultation report dated March 24, 1990. (Dir. Ex. 15) He noted that the Miner worked in the coal mines for 33 ½ years. Dr. O'Bryan diagnosed the following:

1. obstructive lung disease, probably moderate in severity and due to many years of cigarette abuse. Suspect he has a moderate obstructive impairment.
2. Black lung pneumoconiosis, category I.
3. Unstable angina.
4. Chronic bronchitis.
5. History of diabetes mellitus.

6. History of pulmonary embolus about ten years ago.

7. Hypertension.

A hospital record dated April 30, 1995 indicated that the Miner was admitted in full cardiac arrest from which he did not recover. (Dir. Ex. 36) The cause of death was listed as cardiac arrest caused by acute myocardial infarction caused by arteriosclerotic heart disease.

The Miner's death certificate indicates that the Miner's immediate cause of death was cardiac arrest due to acute myocardial infarction and atherosclerotic heart disease. (Dir. Ex. 12)

Dr. Blue, one of the Miner's treating physicians, submitted a letter dated February 2, 1996. (Dir. Ex. 37) Dr. Blue stated that the Miner had two significant problems, with a third being related to the first two. He stated that the three disease entities were:

1. Lung disease secondary to pneumoconiosis and lack of oxygenation.

2. Metabolic problems with sugar and fat metabolism.

3. Hypertension.

He further stated that the Miner's most significant problem was the lung disease which was a result of many years in the coal mines, and a decreased oxygenation of his peripheral tissues because of the lung disease. Dr. Blue made the following statement:

> The arterial sclerotic [sic] heart disease which eventually and quite rapidly caused his demise was largely due to the product of a decreased oxygenation

> on his major arteries and the metabolic stresses from his intermediary metabolism which of course was directly related to the lack of oxygenation which was secondary with his pneumoconiosis.

Dr. Blue opined that the Miner was "a product of many years in the mines with the primary lack of oxygenation to his tissues speeding his death significantly." Finally, he stated that the Miner's immediate cause of death was the coronary artery disease which was largely a result of the chronic low oxygen assaturation superimposed on his metabolic abnormalities of sugar and lipids. Dr. Blue concluded by making the following statement: "It is my opinion that his pneumoconiosis was probably ⅓ to ½ responsible for his final demise." Dr. Blue also submitted some treatment notes. On several occasions from 1991 through 1994, Dr. Blue's records indicate the existence of chronic obstructive pulmonary disease. Dr. Blue also consistently noted diabetes, hyperlipidemia and hypertensive cardiovascular disease.

Dr. Younes reviewed the Miner's medical records and issued a report dated March 14, 1996. (Dir. Ex. 38) Based on his review of the evidence, he stated that the Miner had chronic bronchitis, secondary to his history of heavy smoking and also from coal dust exposure. Dr. Younes further opined that the pneumoconiosis was not a contributing factor to the Miner's death. Specifically, Dr. Younes stated that the circumstances of the Miner's death were not elaborated upon adequately in records sent to him. He noted that the Miner's family physician stated that the Miner's major problems were related to his Coronary Artery Disease and Diabetes.

Dr. Branscomb also reviewed the Miner's medical records and submitted a report dated August 23, 1996. (Er. Ex. 1) He concluded that the Miner did not have occupational pulmonary disease or coal workers' pneumoconiosis. He noted that the Miner was a very obese hypertensive diabetic with severe coronary artery disease which ultimately led to many cardiac problems, including his ultimate death. Specifically, Dr. Branscomb stated:

> His [the Miner's] clinical management was directed principally toward controlling the hypertension and angina, the obesity, encouraging smoking cessation, orthopedic problems, and pulmonary embolism with pneumonia and atelectasis in the lower part of the chest. Some histories indicated coughing and wheezing attributable to chronic bronchitis secondary to smoking. He probably did have mild COPD but fortunately it resulted in no measurable pulmonary impairment. . . . His death was the result of coronary artery disease for which he had many risk factors. It was in no way caused, hastened, not was the cardiac disease in any way aggravated by pulmonary disease or by coal mine dust exposure. Although he had no CWP, if I assume he did, there would still be no reasonable basis for attributing any aggravation, contribution to, or acceleration of his death as a result of such pneumoconiosis.

Dr. Fino also reviewed the Miner's medical records and submitted a report dated September 4, 1996. (Er. Ex. 2) Dr. Fino concluded that the Miner did not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure. He based this opinion on the following:

1. The majority of chest x-ray readings were negative for pneumoconiosis.

2. The acceptable spirometric evaluations were normal with no obstruction, restriction, or ventilatory impairment.

3. The normal MVV means that there was no ventilatory impairment due to any obstructive ventilatory defect.

4. Lung volumes are used to "look" at the consistency of the lung tissue. . . . This man had normal lung volumes. There was no over-distention or over-inflation consistent with an obstructive condition nor was there any evidence of under-inflation due to fibrosis of which pneumoconiosis is an example.

Dr. Fino further stated that the Miner had a sudden cardiac death due to atherosclerotic heart disease and acute myocardial infarction. He noted no causal association between his sudden death and coal mine dust inhalation. He further noted that there is no increased incidence of coronary artery disease as a result of coal workers' pneumoconiosis. Dr. Fino explained that coronary artery disease is one manifestation of a systemic condition called atherosclerosis. He then cited to several specific medical sources indicating that there is no increased incidence of coronary artery disease or its sequelae in individuals who have worked in the mines or who have coal workers' pneumoconiosis.

In summary, Drs. Penman, Myers, Simpao, Mercer, O'Bryan, Younes, Johnson and Blue found evidence of coal workers' pneumoconiosis. To the contrary, Drs. Alexander, Branscomb and Fino found no evidence of pneumoconiosis. I give the most weight to the opinions of Drs. Johnson and

Blue, as buttressed by the opinions of Drs. Penman, Myers, Younes and Simpao and several of the Miner's hospital records. Drs. Blue and Johnson were the Miner's treating physicians. More weight may be accorded to the conclusions of a treating physician as he is more likely to be familiar with the Miner's condition than a physician who examines him episodically. *Onderdo v. Director, OWCP,* 958 F.2d 49 (4th Cir. 1992). As stated by the Fourth Circuit in *Adkins v. Director, OWCP,* 958 F.2d 49 (4th Cir. 1992), a comparison of medical reports and tests over a long period of time may conceivably provide a physician with a better perspective than the a non-treating physician. Of the doctors who found no evidence of pneumoconiosis, only Dr. Alexander actually examined the Miner. Drs. Branscomb and Fino were non-examining physicians. It is proper to accord less weight to a consulting or non-examining physicians on the ground that he does not have first-hand knowledge of the miner's condition. *Bogan v. Consolidation Coal Co.*, 6 BLR 1-1000 (1984). Finally, I find that the opinions of the Miner's treating physicians are supported by the well-documented and well-reasoned reports of Drs. Penman, Younes and Simpao. *See Fields, supra; Oggero, supra.*

Accordingly, I find that the opinions of Drs. Alexander, Branscomb and Fino are outweighed by the opinions of Drs. Johnson, Blue, Penman, Myers, Younes and Simpao. As such, the Claimant has established, by a preponderance of the medical evidence, hat [sic] the Miner suffered from coal workers' pneumoconiosis under § 718.202(a)(4).

Death Due to Pneumoconiosis:

As discussed above, the Claimant in this case must prove that the Miner's death was hastened by pneumoconiosis. *Brown, supra.* The medical opinion evidence is summarized above and will not be repeated here.

Based on a thorough review of all the evidence contained in the record at this time, I find that the Claimant has not met her burden of establishing that the Miner's death was at least hastened by pneumoconiosis. The Miner's death certificate, as supported by his hospital and treatment records, as well as the opinions of Drs. Younes, Branscomb and Fino, indicate that the immediate cause of death was cardiac arrest due to acute myocardial infarction and atherosclerotic heart disease. Only Dr. Blue opined that the Miner's death was hastened by pneumoconiosis. However, I find that Dr. Blue's opinion is outweighed by the well-reasoned and well-documented opinions of Drs. Branscomb and Fino. *See Fields, supra; Oggero, supra.* To the contrary, Dr. Blue's opinion regarding the factors contributing to the Miner's death is not well-documented.[5] An undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (*en banc*). Based on the foregoing, I find that the Claimant has failed to establish that the Miner's

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[5] I note that a judge need not find that a medical opinion is either wholly reliable or wholly unreliable. Rather, the opinion may be divided into the relevant issues of entitlement to determine whether it is reasoned and documented with regard to any particular issue. *Drummond Coal Co. v. Freeman,* 17 F.3d 361 (11th Cir. 1994). Therefore, it is proper for me to accord greater weight to Dr. Blue's opinion regarding the existence of pneumoconiosis and less weight to his opinion regarding the factors causing the Miner's death.

death was hastened by pneumoconiosis. Accordingly, the Claimant has failed to satisfy the criteria set forth in § 718.205(c).

Entitlement:

As the Claimant has failed to establish that the Miner's death was at least hastened by pneumoconiosis, I find that she is not entitled to benefits under the Act.

Attorney's Fees:

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Because the benefits are not awarded in this case, the Act prohibits the charging of any attorney's fee to the claimant for legal services rendered in pursuit of benefits.

ORDER

It is therefore ORDERED that the claim of Wilma G. Groves for benefits under the Act remains DENIED.

s/_____
THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing a notice of appeal with the Benefits Review Board, P.O. Box 3760, Washington, D.C. 20013-7601. *A*

copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, D.C. 20210.

00-3867

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

PEABODY COAL COMPANY, Petitioner, v. WILMA L GROVES; ET AL; Respondents.	FILED APR 12, 2002 LEONARD GREEN, Clerk

BEFORE: KENNEDY, MOORE, and COLE, Circuit Judges.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied. Judge Kennedy would grant rehearing for the reasons stated in her dissent.

ENTERED BY ORDER OF THE COURT

s/ _____
Leonard Green, Clerk

STATUTES AND REGULATIONS

5 U.S.C. § 556(d)

(d) Except as otherwise provided by statute, the proponent of a rule or order has the burden of proof. Any oral or documentary evidence may be received, but the agency as a matter of policy shall provide for the exclusion of irrelevant, immaterial, or unduly repetitious evidence. A sanction may not be imposed or rule or order issued except on consideration of the whole record or those parts thereof cited by a party and supported by and in accordance with the reliable, probative, and substantial evidence. The agency may, to the extent consistent with the interests of justice and the policy of the underlying statutes administered by the agency, consider a violation of section 557(d) of this title sufficient grounds for a decision adverse to a party who has knowingly committed such violation or knowingly caused such violation to occur. A party is entitled to present his case or defense by oral or documentary evidence, to submit rebuttal evidence, and to conduct such cross-examination as may be required for a full and true disclosure of the facts. In rule making or determining claims for money or benefits or applications for initial licenses an agency may, when a party will not be prejudiced thereby, adopt procedures for the submission of all or part of the evidence in written form.

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5 U.S.C. § 706

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and

determine the meaning or applicability of the terms of an agency action. The reviewing court shall –

(1) compel agency action unlawfully withheld or unreasonably delayed; and

(2) hold unlawful and set aside agency action, findings, and conclusions found to be –

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) contrary to constitutional right, power, privilege, or immunity;

(C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;

(D) without observance of procedure required by law;

(E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or

(F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court. In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

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33 U.S.C. § 919(d)

(d) Provisions governing conduct of hearing; hearing examiners. Notwithstanding any other provisions of this Act, any hearing held under this Act shall be conducted in accordance with the provisions of section 554 of title 5 of

the United States Code [5 USC §§ 554]. Any such hearing shall be conducted by a [an] administrative law judge qualified under section 3105 of that title [5 USC § 3105]. All powers, duties, and responsibilities vested by this Act, on the date of enactment of the Longshoremen's and Harbor Workers' Compensation Act Amendments of 1972 [enacted Oct. 27, 1972], in the deputy commissioners with respect to such hearings shall be vested in such administrative law judges.

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33 U.S.C. § 921(c)

(c) Court of appeals; jurisdiction; persons entitled to review; petition; record; determination and enforcement; service of process; stay of payments. Any person adversely affected or aggrieved by a final order of the Board may obtain a review of that order in the United States court of appeals for the circuit in which the injury occurred, by filing in such court within sixty days following the issuance of such Board order a written petition praying that the order be modified or set aside. A copy of such petition shall be forthwith transmitted by the clerk of the court, to the Board, and to the other parties, and thereupon the Board shall file in the court the record in the proceedings as provided in section 2112 of title 28, United States Code [28 USC § 2112]. Upon such filing, the court shall have jurisdiction of the proceeding and shall have the power to give a decree affirming, modifying, or setting aside, in whole or in part, the order of the Board and enforcing same to the extent that such order is affirmed or modified. The orders, writs, and processes of the court in such proceedings may run, be served, and be returnable anywhere in the United States. The payment of the amounts

required by an award shall not be stayed pending final decision in any such proceeding unless ordered by the court. No stay shall be issued unless irreparable injury would otherwise ensue to the employer or carrier. The order of the court allowing any stay shall contain a specific finding, based upon evidence submitted to the court and identified by reference thereto, that irreparable damage would result to the employer, and specifying the nature of the damage.

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20 C.F.R. § 718.104(d)

(d) Treating physician. In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was, totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:

(1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) Duration of relationship. The length of the treatment relationship demonstrates whether the

physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication officer shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.